



Protecting New Jersey's Children and Families from Substance Abuse

**Report to
Commissioner Gwendolyn L. Harris
Department of Human Services
and
The New Jersey State Legislature**

**Submitted by
Child and Family Services Review
Substance Abuse Work Group**

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II. Executive Summary

The presence of substance abuse in the incidence of child abuse and family violence is staggering.

Studies show that children from substance abusing households are more likely than others to be placed into foster care, spend longer periods of time in an out-of-home setting, are less likely to return home within one year of placement, and are more likely to have a case goal of adoption.

In addition, alcohol and drug use by a pregnant woman is devastatingly harmful to the unborn child. These infants are more likely to have serious medical complications at birth and continue experiencing behavioral, developmental and medical needs throughout their lifetime.

Substance use affects all aspects of family life, interferes with positive family functioning and in most situations, perpetuates the cycle of substance abuse and child abuse and neglect.

Clearly, with the state's child welfare system on the cusp of a major transformation, now is the time to build more effective bridges between child welfare services and substance abuse treatment to keep children safe and families functioning and whole.

On October 23, 2002, Governor James E. McGreevey signed Executive Order No. 36 authorizing Department of Human Services Commissioner Gwendolyn L. Harris to establish two work groups to examine the relationship between (1) child welfare and substance abuse, and (2) child welfare and domestic violence in New Jersey. The work groups were composed of persons from a cross-section of disciplines and branches of government that interface with the child welfare system. After a series of meetings and discussions from December 2002 through September 2003, the work groups finalized the recommendations contained herein.

These recommendations will be considered as part of an overall plan to dramatically improve child protection services in New Jersey. In June, the state embarked upon a comprehensive federal review of its child welfare system known as the Child and Family Services Review (CFSR). The CFSR represents a collaborative effort between the state and the U.S. Department of Health and Human Services. The review process is an opportunity to enhance services to New Jersey's children and families. Its focus is to keep abused and neglected children safe, achieve timely permanency for foster children, and maintain the well-being of children in foster care.

The recommendations developed by the Substance Abuse Work Group speak to four primary challenges which persist for serving parents and families needing substance abuse treatment: The challenges are: the need for more substance abuse training for Division of Youth and Family Services (DYFS) workers; more appropriate treatment options for at-risk families; safety and permanency plans for children that consider the entire family unit; and better cooperation among the government and non-government entities that touch the lives of children every day.

Training

It is absolutely critical that DYFS staff and other professionals receive more extensive training to identify and assess where substance abuse is present in a family. Unfortunately, this does not now occur in any organized or uniform fashion within the division.

In addition, DYFS staff needs to play a role in developing meaningful and effective treatment strategies that meet the multi-faceted needs of families.

Specifically, the work group recommends the immediate creation of a Certified Alcohol and Drug Training Program for Family Case Workers and Supervisors as well as educating an array of professionals that touch the lives of children every day on the impact of substance abuse on child welfare.

Increase Treatment Program Capacity – Standardize Assessments

It is undeniable that significantly more treatment programs, especially those which provide treatment to pregnant women and the children of substance abusers, must be developed and funded.

To that end, the work group strongly recommends that a regionalized continuum of care that is replicable throughout the state and utilizes nationally recognized best practices be developed. This continuum of care must meet the needs of the child welfare client and family (including pregnant women) and must integrate child safety outcomes into treatment planning, reassessment, discharge and follow-up protocols.

Evaluate Families Holistically – Intervene Early

It is critical that children's safety and service plans be built on the strengths of the family so that permanency options – including reunification – can be accomplished more quickly and effectively. The best way to achieve this goal is to identify substance abuse issues in a family and to intervene early.

Given the fact that most families affected by substance abuse interact with numerous state and community resources, it is vital that these various and disparate entities operate with shared case practice standards. To this end, the work group recommends

that such case practice handling standards be developed and implemented for DYFS district office staff and shared with substance abuse treatment providers, welfare agencies, the court system and the many community agencies that partner with DYFS.

In addition, DYFS should expand community services to assess the developmental needs of children and expand child and adolescent-specific treatment resources that support children in their own homes by increasing home visitor and substance abuse counseling services throughout the state, and hiring 48 additional nurses and nurse practitioners to work with DYFS staff.

System Collaboration

All of the systems that touch children's and families' lives – the schools, the courts, law enforcement, mental health providers, etc. – must work together to develop useful programs for at-risk families.

In order to accomplish this, the work group recommends that the state establish a Statewide Advisory Committee on Substance Abuse and Child Welfare (SACSACW) and that DYFS develop county-based Interagency Coalitions on Substance Abuse and Child Welfare.

The role of the county-based coalitions will be to: advocate for “on demand” substance abuse treatment for at-risk families; review practice guidelines; collect community input on substance abuse treatment issues; facilitate community partnerships and establish affiliation agreements for local wrap-around services and case management; foster better inter-agency case management; and develop standards of care to ensure that vulnerable children do not fall through the cracks in the bureaucracy.

Given that at least 75% of all child welfare cases that pass through the family court system are in some way affected by substance abuse, particular attention should be paid to the role the courts play in linking troubled families to treatment options.

To this end, the work group recommends that “Project Safety” -- a flexible model of family supervision which coordinates services for families with substance abuse issues with a goal of either keeping children at home or removing them for short periods during treatment – be created.

Additionally, the work group supports the development of family drug courts and recommends expanded substance abuse training for judges and court staff and volunteers, Deputies Attorney General, Law Guardians and Public Defenders.

These recommendations provide a roadmap for the creation of a child protection system that finally, fully integrates substance abuse treatment for all family members into the array of services available to at-risk families.

Recommendations

1. Establish a Statewide Advisory Committee on Substance Abuse and Child Welfare (SACSACW).
2. Establish countywide interagency coalitions on substance abuse and child welfare.
3. Establish a certified substance abuse training program for DYFS family case workers and supervisors.
4. Provide orientation and on-going training to increase the abilities, skills and knowledge of Family Court judges, staff and volunteers, Deputies Attorney General, Law Guardians, Public Defenders and Child Placement Review Board volunteers on the best practices in order to manage families affected by substance abuse and child maltreatment.
5. Educate and raise awareness among all professionals that touch the lives of children every day concerning the impact of substance abuse on child welfare.
6. Establish a regionalized continuum of care that is replicable and utilizes nationally recognized best practices. Programs are to be developed or enhanced that are tailored to the specific needs of the child welfare client and family (including pregnant women).
7. Develop Case Practice Standards for district office staff of the Division of Youth and Family Services (DYFS).
8. Ensure that an appropriate number of Certified Alcohol and Drug Counselor (CADC) and Home Visitor resources are in place in all DYFS District Offices (DO) and Adoption Resource Centers (ARC).
9. Meet the complex needs of children affected by substance abuse in the child welfare system by hiring an adequate number of nurse/pediatric nurse practitioners for each DO/ARC office to partner with DYFS.
10. Implement "Project Safety," a systems coordinated model of family supervision for DYFS-TANF families affected by parental substance abuse.
11. The Department of Human Services, Division of Youth and Family Services should coordinate and collaborate with the Administrative Office of the Courts to discuss the viability of establishing a pilot Family Drug Court for child welfare families in Morris County.
12. Following the full implementation of the above recommendations, consider instituting mandatory substance abuse drug screening and testing for families referred to and under DYFS supervision as well as applicants to the foster and relative caregiver programs.

III. Introduction

New Jersey is the last state in the nation to undergo a comprehensive, federal review of its child welfare system known as the Child and Family Services Review (CFSR). The CFSR represents collaborative efforts between states and the U.S. Department of Health and Human Services. It is conducted by teams of federal staff, peer reviewers, state staff and external participants who collect and analyze information from different child welfare partners, identify a state's strengths and weaknesses and then undertake program improvements as needed. The review process is an opportunity to enhance services to New Jersey's children and families. It is a tool to help states improve child welfare services, and to improve outcomes for children and families. Its focus is to keep abused and neglected children safe, achieve timely permanency for foster children, and maintain the well-being of children in foster care.

After being briefed on the CFSR during the summer of 2002, Department of Human Services Commissioner Gwendolyn L. Harris anticipated that New Jersey might, like all other states, be found not in substantial compliance with the national standards set by the CFSR. She immediately began to plan for child welfare system improvements. Having learned from the experience of other states that were found out of compliance with systemic factors of coordination and service delivery, Commissioner Harris pinpointed domestic violence and substance abuse as two critical areas where effective linkages did not exist despite national data indicating the high prevalence and co-occurrence of child welfare, domestic violence and substance abuse.

In October, Commissioner Harris appeared before two state legislative committees, outlining her suspicions about the state's upcoming performance on the CFSR. Her appearance coincided with the signing of Executive Order No. 36 by Governor James E. McGreevey on October 23, 2002, authorizing the Commissioner to establish two work groups to examine the relationship between child welfare and substance abuse and child welfare and domestic violence in New Jersey. The executive order directed the work groups to present, in a year, a report to the Commissioner and the Legislature that includes recommendations for improvements through modifications of existing policies, procedures, legislation or regulations as well as focusing on various community, advocacy and interdepartmental partnerships. The work groups were composed of persons from a cross-section of disciplines that interface with the child welfare system and had their orientation in December 2002.

In addition to the preparations underway for the CFSR, the urgency for necessary child welfare reforms moved directly to the forefront as news of several tragic deaths involving children under the supervision of the Division for Youth and Family Services (DYFS) were reported. Commissioner Harris announced in February 2003 that 123 children had died due to abuse or neglect

in New Jersey in the past five years -- a rate of nearly 25 children per year. Of the 123 deaths, two-thirds of the children were from families under DYFS supervision or with closed DYFS cases. A particular concern was the fact that children age one and under accounted for almost 57% of the 123 deaths. Prenatal drug use was present in 23% of the child deaths under age one (NJ Department of Human Services, 2003). These statistics have clearly exposed shortcomings in New Jersey's child protection system.

By the end of August 2003, the number of children receiving DYFS case management totaled 58,582, with 46,427 (79%) residing in their own home and 12,335 (21%) in out-of-home placement. Of the children in out-of-home placement, 5,691 were residing in a foster home, while the remainder were residing in kinship care, a residential treatment facility, or a shelter (NJ Department of Human Services website). Many of these families are not only experiencing substance abuse issues in the home, but domestic violence issues as well.

According to the DYFS Annual Report from May 2002, domestic violence was reported as one of the top three parent issues referred to DYFS in the year 2000, accounting for over 2,300 reports, a number likely much lower than the true prevalence. The DYFS report also indicated that in the year 2000, at least one caregiver was known to have a substance abuse problem in 33.1% of all substantiated child abuse and neglect cases and substance abuse was suspected among another 6.2% of all substantiated child abuse and neglect cases.

New Jersey's primary child welfare agency is in need of urgent reform. A successful transformation of DYFS will require reform throughout the entire child welfare system, not simply DYFS alone. It must include early intervention and treatment for substance abuse for troubled families. The CFSR comes at an opportune time for promoting and supporting such progressive change.

This report, and the recommendations herein, is intended to inspire the development of innovative and collaborative policies and practices. The recommended reforms are designed specifically to meet the needs of families, placing opportunities for recovery from substance abuse within reach. Accordingly, as a parent's prospects for recovery improve so does their child's safety and well-being.

IV. Substance Abuse and the Child Welfare System

A. The Problem

The effects of substance abuse impair parenting skills and threaten the safety and well-being of children. Substance abuse interferes with an individual's general functioning in a number of ways and can seriously compromise a parent's competence to protect their child. Substance abuse can:

- Interfere with thought processes and can impair a parent's judgment and protective capacity.
- Interfere with a parent's ability to respond consistently and sensitively to a child.
- Reduce the emotional and physical availability of the parent to attend to the child's needs.
- Result in spending household money for food and other basic needs on alcohol and other drugs.
- Lower a parent's upper limit of aggression toward children.
- Be associated with other illegal activities that place a child's health and safety at risk.
- Promulgate the neglect of a child's routine health care needs including immunization schedules (Young, Gardner, Dennis, 1998).

Nationally, more than 6 million children lived with at least one parent who abused or was dependent on alcohol and/or illicit drugs during the past year. Younger children are particularly vulnerable to abuse and neglect by a substance abusing parent, while older children with mental, emotional, physical disabilities or who have been previously victimized often cannot protect themselves. The Substance Abuse and Mental Health Services Administration (SAMHSA) report indicates that in 2001, 10% of children aged five or younger lived with a parent who was dependent upon or abused substances in the past year (National Institute on Drug Abuse, Vol. 17, No. 1).

Children who were exposed prenatally to illicit drugs were two to three times more likely to be abused or neglected. Children whose parents abused alcohol or drugs regardless of prenatal exposure were three times likelier to be abused and four times more likely to be neglected compared to the children of parents who did not abuse substances (Reid, Macchetto and Foster, 1999). At least half the children in the custody of child welfare have been placed there in part because of parental substance abuse (Young, et al., 1998), and substance abuse causes or exacerbates seven out of every 10 cases of abuse or neglect (Reid, Macchetto and Foster, 1999). Thirty-six states nationwide report that parental substance abuse and poverty are the top two problems exhibited by families reported for child maltreatment (National Committee to Prevent Child Abuse, 1998).

Child welfare workers are aware that most of their cases involve families with drug and alcohol problems, but they know this only anecdotally. Workers are usually not required to ask about substance abuse, and even when they do there are few resources available for treatment. As a result most parents who need addiction treatment do not get it and the safety of their children remains at risk, while opportunities for recovery and improving family and child well being are forfeited (Young and Gardner, 2002) .

New Jersey

The DYFS 2002 Annual Report indicated that in the year 2000, DYFS workers substantiated 967 abuse/neglect reports that involved prenatal substance abuse. These cases accounted for 11.1% of all substantiated cases statewide. At least one caregiver was known to have a substance abuse problem in 33.1% of all substantiated abuse and neglect cases and substance abuse was suspected among another 6.2% of all substantiated abuse and neglect cases. The victim was under five years of age in 54% of substantiated cases where substance abuse was confirmed. Seventy-eight percent of the victims were less than ten years of age (DYFS Annual Report, 2002).

The issue of substance abuse as a serious factor in cases of child abuse and neglect is underscored by the 1998-2002 "Child Fatality Analysis" which indicated that drug use during pregnancy contributed to 13% of the 123 child deaths caused by abuse or neglect in New Jersey between the years of 1998 and 2002. Drug use during the mother's pregnancy was a factor in almost 23% of all child deaths under one year old (NJ Department of Human Services, 2003).

The Substance Abuse Initiative (SAI)

The Department of Human Services and the Department of Health and Senior Services designed a program, entitled the Substance Abuse Initiative (SAI), which provides substance abuse assessments, access to substance abuse treatment, and monitors attendance and participation for eligible Work First New Jersey (WFNJ) recipients. In keeping with the goal of WFNJ, the goal of the SAI is to identify and remove substance abuse related barriers that may prevent an individual from becoming self-sufficient.

The SAI uses two models of case management for their WFNJ clients. The Substance Abuse Research Demonstration (SARD) model, operational in Essex and Camden counties for Temporary Assistance for Needy Families (TANF) recipients, is based on research conducted in Essex and Atlantic counties over a four year period. This model utilizes a cross systems approach to case management for both substance abuse treatment services, as well as, other involved collateral systems including child welfare, housing, and the New Jersey Department of Labor One Stop System. The recipients in the remaining counties

in the initiative receive case management services and linkages solely around substance abuse issues.

This statewide initiative was implemented in August of 1998. SAI staff has been co-located at the local County Welfare Agencies (CWA) when possible. Referrals made through the CWA are based on the results of substance abuse screening tools and are discussed with the WFNJ recipient at predetermined points in the WFNJ application, re-determination, sanction, or conciliation processes.

The SAI employs Clinical Care Coordinators (CCC) who are trained in the assessment of substance use disorders. Once the WFNJ recipient has been assessed, the CCC makes a determination on the level of substance abuse treatment services that would best meet the recipient's clinical needs. The CCC notifies the appropriate staff person at the CWA with the results of the assessment and the status of the recipient. The CCC makes a referral for services to a provider in the SAI provider treatment network and helps the client access treatment, if necessary, using the supportive services offered through the WFNJ program.

The following treatment services are made available to the WFNJ recipient at no cost to the recipient: inpatient detoxification services, residential treatment services (including half way houses), intensive outpatient treatment (including partial care), outpatient treatment, and methadone maintenance. A recipient's full time participation in an assigned substance abuse treatment program fulfills the WFNJ work activity requirement. Another goal of the SAI is to phase in a part or full time work activity through the CWA at the appropriate stage of substance abuse treatment.

Statistics compiled by the SAI indicate that for calendar year 2002, statewide the CWAs referred 3,804 unduplicated General Assistance (GA) recipients to the SAI. Seventy-six percent (or 2,873) of those referrals were assessed and 76% (or 2,173) of the assessments resulted in placement in treatment. The CWAs referred 1,142 Temporary Assistance for Needy Families (TANF) recipients to the SAI and SARD model programs. Of those referred, 72% (or 822) were assessed and 75% (or 616) of assessments resulted in placement in treatment. These numbers appear indicative of trends seen since the program's inception.

For example, the most up to date program data (August 1998 through March 2003) indicates that since the implementation of the SAI, the program has received 15,716 unduplicated referrals (10,730 were GA and 4,446 were TANF). An average of 73% of those referred were assessed and over 70% of those assessed successfully entered treatment. Due to the changes in Medicaid coverage for the GA population, GA referrals to the SAI have increased 181% since 1998.

The Substance Abuse Research Demonstration Project (SARD)

Research from New Jersey's Substance Abuse Research Demonstration (SARD) model on a cohort of participants from September 1998 through June 2002 highlights the sizeable overlap of families served by DYFS and WFNJ/TANF. The profile of SARD program participants is useful in identifying the issues present among DYFS families. In fact, 84% of the SARD program participants reported being investigated by DYFS, 40% reported a currently active case and the average number of investigations per family was seven.

The typical SARD/TANF woman with a substance use disorder (SUD) was in her mid-thirties, unmarried with three to four children, lacked a high school diploma and received welfare benefits for more than 12 years. The women reported serious and chronic substance abuse problems of eight to ten years duration. Seventy percent were addicted to heroin or cocaine. On average women drank heavily or used drugs on about two of every three days in the prior month and had extensive histories of prior substance abuse. Women required intensive treatment placements to address their problems, including one-third who required 28 day inpatient treatment. Despite the severity of substance abuse problems, half of the women had not received prior substance abuse services (Morgenstern et al., 2002).

Over 50% of TANF women in the substance abuse sample presented high levels of co-occurring mental health disorders. The disorders were primarily post traumatic stress disorder (PTSD), depression and anxiety. Clients with severe mental illness, including psychotic symptoms, were excluded from the study. Almost 20% of substance abusing TANF clients in the study had a current PTSD diagnosis, compared with 2.9% of the non-substance abusing TANF sample, and 45.1% of the substance abusing TANF sample had severe to moderate depressive symptoms, compared with 8.7% of the non-substance abusing TANF sample (Morgenstern et al., 2002).

In addition, TANF women in the substance abuse sample evidenced high levels of other problems, particularly in the areas of family relations including domestic violence, legal, basic needs, and stressful events. About one in three reported serious family problems in the recent past: 35% reported high levels of family conflict and 31% reported being the victim of severe physical violence from a partner. Childcare issues were also a problem for an overwhelming majority of TANF substance abusers (Morgenstern et al., 2002).

Over half (56%) had been arrested and 25% had been incarcerated. Women also reported high levels of problems meeting their basic needs: 51% reported living in unstable housing and 40% reported serious problems with transportation. In addition, 65% experienced a major stressful event (e.g., serious illness of child, being evicted) in the last year. Not surprisingly, the women indicated requiring additional services in multiple areas, from multiple

systems beyond substance abuse treatment. The needs for services, in addition to substance abuse treatment, were as follows: 46% required mental health services, 51% required family treatment, and 21% required legal services (Morgenstern et al., 2002).

The study also examined indicators of child well being based on the mothers' report. Among older children (ages 6-17) substance abusing mothers reported significantly greater physical, behavioral, and academic problems. Differences were greatest for parents of adolescences (ages 12-17). Substance abusing mothers reported high levels of physical health problems (20%) and risk behaviors with their children. Seventeen percent reported having a child who became pregnant as a teen, 12% reported having a child who was arrested, and 40% reported having a child who was expelled or suspended from school (Morgenstern et al., 2002).

Overall, the study findings indicate that women identified in welfare settings as dependent on alcohol or other drugs experience high levels of psychosocial impairment, child welfare involvement and family dysfunction. These women differ from other women on TANF and are unlikely to transition into employment through the typical welfare-to-work employment and training programs.

The serious and chronic substance abuse problems combined with child abuse and neglect issues require intensive treatments with strong aftercare and follow up components. In addition, the level of problem severity suggests that relapse will be a common phenomenon even among those who complete treatment. Findings also indicate the need for additional services from multiple systems: including mental health, family treatment, basic needs, and medical services. These findings are consistent with earlier studies suggesting that substance-abusing mothers have multiple co-occurring problems, but raise concerns because standard substance abuse treatment does not typically provide these services.

Overall, the findings suggest alarmingly high levels of family dysfunction. On average, substance abusing TANF mothers were investigated multiple times by DYFS, one-third reported severe domestic violence, and many reported teenage children engaging in high risk behaviors. They raise questions about expected time frames for substance abusing Work First New Jersey (WFNJ) parents with DYFS involvement to stabilize their families and become employed. They also raise questions about the unintended effects of the WFNJ policies on families involved in both the welfare and child welfare systems.

When the State transformed welfare into the WFNJ employment program, very little was known about the families' simultaneous involvement in the DYFS system or the seriousness of their substance abuse problems. Consequently, it was not known how policies that denied welfare benefits to some WFNJ parents

convicted of drug-offenses, would affect the safety of children, the termination of parental rights and family permanency goals.

To date, most discussions about substance abusing DYFS parents have focused on the need for substance abuse treatment. However, it seems unlikely that DYFS-WFNJ parents will be able to stabilize their families and secure or sustain employment without a comprehensive cross-systems approach.

The Child Protection Substance Abuse Initiative (CPSAI)

The Department of Human Services Child Protection Substance Abuse Initiative (CPSAI) is a DYFS contracted program that provides substance abuse assessment and referral to treatment integrated into DYFS child safety case practice. The main handicap of this program is the lack of explicit resources set aside to fund treatment services for families. Following assessment, consultants work with diagnosed families to place them in an appropriate level of care utilizing available resources for treatment within the Department of Health and Senior Services' licensed provider network.

Overall the CPSAI program in fiscal year 2003 received 8,564 DYFS referrals, conducted 6,193 assessments, positively diagnosed 3,468 clients, and placed 2,104 clients in treatment.

TOTALS	Referred	Assessed	Diagnosed	Placed in Treatment
Statewide CPSAI Totals (FY03)	8,564	6,193	3,468	2,104
Statewide SAI totals (Calendar year 02)	4,946	2,995	Not avail.	2,789

Drug Treatment

Unfortunately, substance abuse prevalence and its related problems are robust in New Jersey. The total alcohol and drug arrest rate in New Jersey is 51.1 out of 1,000 people and the age adjusted death rate for all causes of substance abuse mortality for 1998 was 441.8 out of 100,000 people.

Comparing 1999 substance abuse admissions data from New Jersey with the national average, on the whole New Jersey has a slightly higher rate of admissions (788 per 100,000) than the national average (719 per 100,000). However, there is a sharp contrast between the rate of admissions for heroin and other opiates in New Jersey (345 per 100,000) compared with the national average (115 per 100,000). This contrast is in concert with regional differences nationwide. Heroin admission rates were highest in the Pacific and Middle

Atlantic States. While the rate for the United States as a whole was stable over the period 1994 -1999, heroin admission rates increased between 1994 and 1999 by 100 percent or more in 15 states.

Admissions per 100,000 aged 12 and over, 1999 (SAMHSA, 1994-1999 Treatment Episode Data Set (TEDS) www.dasis.samhsa.gov)								
	Total	Alcohol	Opiates (Heroin +others)	Cocaine	Marijuana/ Hashish	Stimulants	Tranquilizers and Sedatives	Halluci- nogens
National Average	719	337	115	104	103	32	3	1
New Jersey	788	256	345	93	79	1	4	1

The latest data from the Division of Addiction Services in the NJ Department of Health and Senior Services indicates that overall the drug abuse treatment admissions rate for the year 2000 in New Jersey is 441.8 out of 100,000 people. The alcohol abuse treatment admissions rate for the year 2000 is 189.1 out of 100,000 people-- totaling over 50,000 alcohol and drug treatment admissions in the state of New Jersey in the year 2000.

The fortunate news is that addiction and its related problems can be treated successfully. Studies by SAMHSA show that nearly one-third of individuals in recovery achieve abstinence from their first attempt at recovery and one-third have brief periods of relapse but eventually achieve long-term abstinence. These statistics are consistent with the lifelong recovery rates of any chronic lifestyle-related illness, such as diabetes, asthma, and hypertension.

Given the prevalence of heroin abuse in New Jersey it is important to address the relevance of methadone maintenance, specifically, as an effective course of treatment. In New Jersey 48% of substance abuse admissions indicated heroin as the primary drug of abuse (New Jersey DAS 2001 annual statistical perspective). This statistic is markedly higher than the national data indicating heroin as the primary drug of abuse in 18% of national substance abuse admissions (Schneider Institute for Health Policy, 2001).

Research shows that in the year after treatment for one of the four most common types of drug treatment programs--outpatient methadone, methadone maintenance reduced heroin use by about 70 percent. (Schneider Institute for Health Policy, 2001)

For pregnant, substance-using women the effects of heroin on the pregnancy include: 1) toxemia, 2). intrauterine growth retardation, 3) miscarriage, 4) premature rupture of membranes, 5) infections, and 6) breech presentations. Effects on the woman include: 1) poor nutrition with vitamin deficiencies; 2) medical complications from use including abscesses endocarditis, ulcers, hepatitis, urinary tract infections; 3) sexually transmitted diseases including gonorrhea, chlamydia, syphilis, herpes, and HIV; and 4) hypertensive disorder

(Presentation by; Louis E. Baxter, Sr., M.D., FASAM, Drug And Alcohol Treatment Of Women And Women With Children).

Effects of heroin on the fetus and newborn infant include; low birth weight, prematurity, neonatal abstinence syndrome, stillbirth, and sudden infant death syndrome (SIDS) (Improving Drug Treatment for Drug-Exposed Infants, SAMHSA website, 2003, www.healthorg.govpubs/bkd110/5d4.aspx).

Maternal methadone maintenance is a valuable treatment modality when administered under medical supervision. Although methadone poses some threat to the fetus, it is important to contrast the benefits of methadone in pregnancy with the risks associated with the continuing use of heroin. For this reason, methadone maintenance is often recommended for pregnant opioid-dependent women. Methadone maintenance during pregnancy provides the following benefits: assists women in staying heroin free, leads to more consistent prenatal care, lessens possibility of fetal death, lessens decreased fetal growth and improves growth of newborn, enhances the woman's ability to prepare for the birth of the infant and begin parenting, reduces risk of HIV infection, reduces obstetrical complications and enables the woman to breastfeed her infant.

New research funded by the National Institute on Drug Abuse (NIDA), published in the October 17, 2003 edition of the Journal of the American Medical Association, clearly shows that longer-term methadone maintenance therapy (MMT), combined with some psychosocial counseling, is a far more effective treatment for heroin addiction than is simply the temporary use of methadone to detoxify patients and reduce drug craving, even when the detoxification is coupled with much more intensive psychosocial therapy (www.drugabuse.gov/MedAdv/00/NR3-7.html).

In fact, for pregnant opiate dependent women detoxification is contraindicated and medical withdrawal is not recommended. Methadone maintenance is the treatment of choice in opiate dependent patients (Presentation by; Louis E. Baxter, Sr., M.D., FASAM, "Drug and Alcohol Treatment of Women and Women with Children").

A 1996 SAMHSA study found that one year post treatment abstinence rates for 495 women seeking to regain or retain custody of their children were highest for cocaine users (70% to 71% for powdered cocaine users and 52% to 62% for crack cocaine users) and were 50% for heroine users. The same study also calculated abstinence rates by treatment modality for female clients seeking to regain custody of children. One year post treatment, women receiving outpatient treatment (not including methadone) experienced an abstinence rate of 48%, and 44% and 46% abstinence rates for short-term and long-term residential treatment respectively (National Institute on Drug Abuse, Vol. 17, No.1).

While child welfare outcomes are rarely measured by substance abuse treatment programs targeting women with children, one 1995 SAMHSA study of grantees operating substance abuse treatment programs targeting women with children reported that 75% of their clients who successfully completed treatment remained drug free; 46% obtained employment following treatment; and 65% of clients' children in foster care were reunited with their families (National Institute on Drug Abuse, Vol. 17, No.1).

While substance abuse treatment does have a proven successful track record for those engaged in a full course of treatment services many individuals never enter or do not complete a full course of treatment services for a variety of reasons. Additionally, while the full course of treatment may be effective, the timeline for recovery may extend beyond the allowable time line requirements for child welfare placement.

The Adoption and Safe Families Act

The Adoption and Safe Families Act (ASFA), (P.L. 105-89), signed into law on November 19, 1997, requires states to move children more quickly through foster care into permanent homes. Previously, federal law did not require states to initiate termination of parental rights proceedings based on a child's length of stay in foster care, but ASFA requires that a termination of parental rights proceedings be initiated when a child has been under the responsibility of the State for 15 of the most recent 22 months.

The recovery process often requires a more protracted timeline than the ASFA requirements accommodate. Substance abuse research has shown unequivocally that good outcomes are contingent on adequate length of treatment, which may be incompatible with child welfare deadlines for parents.

Implementation by states of ASFA clearly demands a new level of cooperation between the courts, child welfare agencies and substance abuse treatment providers. ASFA's time line demands:

- A closer agreement on shared outcomes among courts, substance abuse treatment agencies and child welfare agencies;
- Substance abuse treatment monitoring systems that can report on client's progress;
- Timely access to substance abuse treatment that responds to the 6-12 month timeframes for termination of parental rights; and
- Education for both child welfare workers and substance abuse treatment providers in the requirements of ASFA (Young and Gardner, 2002).

Of the CFSR six national standards, NJ has the greatest variance from the national standards in the measures for family reunification and adoption. On the measure of the percentage of all children who were reunified with their parents or

caretakers at the time of discharge from foster care in less than 12 months from the time of the latest removal from home, the national standard is 76.2% or more and NJ measured 60.6% in federal fiscal year 2002.

On the measure of the percentage of all children who exited care to a finalized adoption (i.e., what percentage exited care in less than 24 months from the time of the latest removal from home), the national standard is 32.0% or more and NJ measured 17.1% in federal fiscal year 2002. Eight out of 32 states reviewed under the CFSR did manage to achieve 32% or more for this measure.

Co-occurring Mental Health, Social, and Intergenerational Factors

Not only does the data indicate that the co-occurrence of child abuse and neglect and substance abuse is prevalent, but often families experiencing substance abuse and child abuse also have additional complex and interconnected concerns related to poverty, risk of homelessness, domestic violence, poor physical and mental health, low literacy levels, etc. The multi-faceted needs of these families challenge providers and social service agencies to develop innovative and comprehensive approaches to effectively meet their needs.

Particularly among women, mental illness and substance abuse are often intertwined. Over one third of females with problem drug use have experienced a major depressive episode in the past year, and 45% have experienced at least one of several mental health problems including panic attacks and anxiety disorders. These rates are more than double those for men with similar levels of substance use (HHS/SAMHSA, 1997). It has been hypothesized that for many women with substance use disorders, drug use may in part represent self-medication, that is, drugs are being used to alleviate psychiatric symptoms (Dackis and Gold, 1992).

While substance abuse may give rise to maltreatment, the converse is also true. Child abuse, and in particular sexual abuse, may lead victims to abuse alcohol or other drugs as they self-medicate to treat their trauma, resulting in intergenerational patterns of substance abuse and child abuse. Women who experienced any type of sexual abuse in childhood were roughly three times more likely than non-abused girls to report drug dependence as an adult (National Institute on Drug Abuse, Vol. 17, No. 1).

The relationship between domestic violence and substance abuse is well documented and recent consensus holds that failure to address domestic violence issues interferes with treatment effectiveness and increases the risk of relapse (HHS/SAMHSA, 1997).

Families involved with the child welfare system are among the most troubled in our society. In families where maltreatment occurs, maltreatment is rarely the only issue. Serious difficulties combine in the lives of families to produce

extremely complex situations, in which addressing the substance abuse alone is not likely to produce the lasting change a family needs to ensure the safety and well-being of its children.

B. Methods

The Child and Family Services Review Substance Abuse Work Group held its orientation meeting on December 10, 2002.

Members of the work group consisted of professionals representing different expertise from diverse governmental and non-governmental systems, as well as statewide geographic dispersion and diverse racial and ethnic backgrounds. A total of 25 members make up the Substance Abuse Work Group. The government sector representation included two Executive Branch department representatives, two Judicial Branch representatives, and one Legislative Branch representative. Also, local judicial representation was included. The statewide non-governmental sector included representatives from the Medical Society of New Jersey and the New Jersey Chapter of the National Counsel on Alcoholism and Drug Dependence. The regional and local non-government sector incorporated representation from legal services, maternal and child health consortiums, and the faith based community. Finally, substance abuse clinical experts included psychologists, academicians, and medical doctors.

Below is a summary of presentations made before the Substance Abuse Work Group. Information provided during the presentations and the ensuing discussions laid a foundation for the work group members for developing their recommendations.

In the orientation meeting Donna Younkin from DYFS provided an overview of the Child and Family Services Review process by briefly explaining how the State of New Jersey's mission, vision, and core values relate to the goals of the CFSR. During the meeting, Department of Human Services Commissioner Gwendolyn Harris introduced the charge of the workgroup.

Throughout the initial five meetings certain presentations were structured to further orient the group to the overlapping issues of substance abuse and child welfare. The group watched a video entitled: "Working with Substance Abusing Families." A presentation by work group member Maria McGowan of DYFS offered a system overview on "The Impact of Substance Abuse on Safety, Permanency, and Well Being". In addition, Assistant Commissioner Carolann Kane-Cavaola from the Department of Health and Senior Services' Division of Addiction Services gave a presentation discussing the need for: 1) more formal collaboration between Division of Addiction Services, DYFS, and the criminal justice system; 2) a neutral assessment instrument; 3) gateway services; 4) self-identification as a substance abuser; and 5) licensing of addiction specialists.

The discussion following the presentations centered on strategies to externally motivate clients seeking treatment, and how to improve engagement and retention in treatment. Recent research findings debunk the myth that clients must be internally motivated in order to achieve positive treatment outcomes. Strategies utilizing external motivation to initiate engagement have proven successful. Suggestions for accelerating client motivation ranged from offering low cost incentives for treatment attendance and abstinence to implementing mandatory measures for treatment attendance. In addition, the workgroup discussed how treatment retention rates could be improved by designing programs to more appropriately meet the needs of families, including on-site resources for children and childcare.

Judge Sallyanne Floria of the Essex County Family Court presented a discussion offering the court systems' perspective on barriers to accessing services including: locating and scheduling transient clients for court ordered assessments when contracted specialists have limited availability; the system's limited capacity for treatment of pregnant women and adolescents; and ASFA timeframes that do not conform to substance abuse treatment timelines.

The work group discussions that ensued emphasized that the sharing of information concerning a case would inform the court and could likely result in different outcomes. For example, treatment providers could benefit from having information from DYFS caseworkers, but do not ask for it. Since termination of parental rights cases often rest on the degree of bonding achieved between the parent and child, the quality of the information presented by a DYFS caseworker at the hearing plays an important role in the case's outcome.

The group raised the issue that there is an unmet need for programs for pregnant women, pregnant teens, and women with children who are in need of residential placements.

Dr. Linda Jeffrey from the Center for Addiction Studies at Rowan University gave a presentation on "The Interplay between Substance Abuse and Domestic Violence and Their Effects on Children and Families".

Dr. Jeffrey's presentation underscored the importance of transforming the working environment of the Division of Youth and Family Services (DYFS) workers to accommodate the prevalent reality of high rates of substance abuse and domestic violence among the DYFS client population. Suggestions offered during the meeting included: creating regional training institutes that incorporate substance abuse, domestic violence, and abuse and neglect topics; creating county-wide multidisciplinary teams; creating county-based family drug courts; increasing the number of well trained paraprofessional supports for workers and include these paraprofessionals in intervention teams; and providing more resources for DYFS workers to manage issues of stress, vicarious trauma, and organizational skills.

Ray Cortese of the Gateway Maternal Child Health Consortium and Judith Morales of the Northern New Jersey Maternal Child Health Consortium presented “A Look at Perinatal Substance Use in 2003”. Mr. Cortese and Ms. Morales highlighted the barriers to treatment faced by pregnant substance abusing women in New Jersey which include: the lack of centralized treatment services; the inconvenient location of treatment facilities in rural settings, making transportation an issue; the lack of a centralized directory of treatment services and programs resulting in inefficient utilization of services since availability is unknown to prospective clients; the lack of gender specific treatments, thereby underscoring the belief by women that they are being judged more harshly by society; the decreased likelihood of receiving support from family; and childcare issues.

The other presentations in the meetings focused on best practice model programs working with families who are experiencing both substance abuse and child welfare issues.

Annette Riordan, from the Office of Planning and Evaluation in the New Jersey Department of Human Services, provided a brief overview of the Substance Abuse Research Demonstration Project (SARD) (also described above). Jon Morgenstern from the National Center on Addiction and Substance Abuse (CASA) at Columbia University in New York presented the Safe Haven model. Safe Haven is a national demonstration project designed to improve safety and other outcomes for children and families affected by substance abuse and child maltreatment. It does this by addressing the problem at three levels: by building family capacity; by building agency capacity; and by establishing family centered policies and systems.

Dr. Morgenstern’s and Dr. Riordan’s presentations brought to light both the challenges and the necessity of developing a cross-systems approach to working with families experiencing substance abuse and child maltreatment. The group’s discussion was attentive to the vision, principles, and process of engaging partners that the work requires. Workgroup members suggested examining existing policies and programs which could be built upon to improve collaboration between the systems, and a SARD-TANF/DYFS collaboration was suggested — as is currently underway in Camden County.

Mary Haack, Ph.D., R.N., F.A.A.N., of the Department of Behavioral and Community Health, School of Nursing, University of Maryland discussed another model project, “Exploring the Feasibility of Family Drug Courts.” Dr. Haack advocated that family drug courts should be instituted in New Jersey noting that Morristown has recently received a grant to institute a family drug court. She also pointed out that the Newark Family Mediation Model merits further consideration as the program proves more satisfying for judges.

Martin DeNero, Community Outreach Manager of the Partnership for Children in the New Jersey Department of Human Services, provided a presentation to the group on “The Children’s Initiative.” The Children’s Initiative is a children’s mental health model that focuses on strengths children and their families already possess. Implementation of the model has led to the establishment of seven family support organizations in seven counties in New Jersey. Cultural competency is an important factor of the model particularly in locations such as Hudson County where over 130 languages are spoken.

The model works to solve the problem of a fragmented system and avoid the problem that occurs when the type of mental health services being delivered are determined by the client’s point of entry into the system. Most counseling and therapy (approximately 80% to 85%) is done directly in clients’ homes; the focus is put on working with families in their homes.

Assistant Commissioner Carolann Kane-Cavaiola, from the Division of Addiction Services in the New Jersey Department of Health and Senior Services, also gave an overview presentation on “Substance Abuse Treatment Models.”

The subsequent group discussion noted that while family treatment is currently a part of most substance abuse treatment programs, adequate funding to address all family members is lacking.

At this point, the work group developed a subcommittee structure in order to facilitate the task of drafting recommendations for the final report. Five subcommittees were established on the following topics: Training, Court Systems, Collaboration, Treatment, and DYFS.

From May through September 2003 the work group meetings mainly focused on sub-committee discussions to draft and refine the recommendations. Only two additional presentations occurred during the last five regular meetings. First, Donna Younkin, Assistant Director of the DYFS Office of Program Support and Permanency, updated the work group on the activities for the Child and Family Services Review. The second presentation was given by John Kriger, President of Kriger Consulting Inc. Mr. Kriger outlined a tri-level community empowerment approach to substance abuse planning, offering a potential framework for the work group’s recommendations.

C. Summary of Recommendations

The recommendations developed by the Substance Abuse Work Group follow. The recommendations here have been organized according to basic challenges which persist for serving parents and families needing substance abuse treatment. In Appendix B, the recommendations are grouped by the branch of government for which there are implications. Fully expanded work plans for the

recommendations as prepared by the work group subcommittees can be found in Appendix C.

Four primary challenges still persist for serving parents and families needing substance abuse treatment.

1. DYFS needs training on both substance abuse assessment and intervention. Innovative and targeted treatment strategies are critical for screening, assessment, engagement and retention in treatment programs designed to specifically meet the multi-faceted needs of families, as well as, increased staff capability to implement these strategies.
2. Capacity of substance abuse treatment service programs across the continuum of care should be increased, including, specialized services for pregnant women and children of parents with substance abuse issues.
3. Families should be evaluated holistically and intervention targeted to reach families early. Safety and service plans must be built on the strengths of the family while addressing permanency and reunification issues for children.
4. Systems collaboration to foster the development of programs that appropriately service this population is essential.

1. Training

Problem: Family Case Workers and Supervisors lack comprehensive, skill-building training programs that are based on established best case practices. The current training system does not ensure consistency across regions and districts relative to substance abuse intervention. Nor is there an evaluation system in place to assess the quality of training, as well as, the capability of Family Case Workers and Supervisors to impact child safety and welfare positively and effectively.

In addition, other professionals interacting with children and families on a daily (or other regular) basis should be required to receive educational instruction that raises their awareness about the impact of substance abuse on child welfare. Such understanding will better enable systems and individual workers to provide the most appropriate and comprehensive services to families.

Recommendation:

Establish and implement a Certified Alcohol and Drug Training Program for Family Case Workers and Supervisors to develop a well-trained corps and enhance the child protection system and environment. The training programs must be skill-based and grounded in strong case practice methodologies. The Family Case Worker Training Program should include

the relationship and effect of poverty on family dynamics, child development (including trauma and disabilities associated with prenatal exposures), alcohol and drug issues, mental health issues, criminal justice issues, public health issues, and ethical decision-making. The program should include training in the use of environmental safety and risk assessment. The training may include didactic elements but should emphasize interactive learning techniques that have practical applications.

Recommendation:

Educate and raise awareness of the impact of substance abuse on child welfare among all professionals that touch the lives of children every day. Develop a fully educated and aware professional response to the coinciding issues of substance abuse and child maltreatment especially among, but not limited to: the Juvenile and Adult Criminal Justice systems, substance abuse and mental health clinicians, and Work First New Jersey staff.

Discussion: Child welfare practitioners are typically insufficiently prepared to identify and respond to families where substance abuse is the predominant problem. They lack skills in interviewing, assessment, decision making, time management and other important competency areas related to substance abusing clients (Depanfilis, 1996). Workers need improved capacity and more appropriate assessment tools to identify the level of risk a parent's substance use poses to children (Dore, Doris, Wright, 1995).

While extensive research has been conducted on screening and assessment instruments used in the substance abuse field, no tools exist that were designed specifically for rating the risk of child abuse or neglect in terms of parental substance abuse (Young, et al., 1998). No standard or accepted indicator determines how or when a parent's use of alcohol or other drugs becomes an increased risk factor to children. With the vast majority of child welfare cases affected by substance abuse, there needs to be an understanding that risk assessment can and should include a substance abuse assessment (Young, et al., 1998).

The assessment process must then also go the extra step to actually connect clients to treatment programs, rather than simply refer with a phone number of the nearest treatment agency (Young and Gardner, 1997).

Often, even when substance abuse treatment is recommended, substance abuse treatment service utilization is low due to high no-show and dropout rates – representing the most serious challenge to the effectiveness of treatment. In particular, substance abuse treatment programs are known for drop out rates that typically run upwards of 50% and may approach 80% in some instances. It is important to note that often outcome data is reported only for those who

complete the full course of treatment (U.S. Department of Health and Human Services, 1999).

Research suggests however, that engagement and retention rates can be significantly improved by programs that are geared toward parents and their children, and are comprehensive, multi-agency, collaborative approaches to treatment services. These programs also demonstrate improved child welfare outcomes (U.S. Department of Health and Human Services, 1999).

Findings from the SARD program research, for example, concluded that intensive case management yielded a two to four fold improvement in treatment engagement. In addition, SARD participants reduced their substance abuse by about 50% more than women participating in “treatment as usual.”

Given the complexity of needs co-occurring in families with simultaneous child welfare and substance abuse issues, a coordinated multi-agency intervention is paramount. Agencies must build staff capacity through education and training to facilitate an appropriate, professional, and coordinated response.

2. Increased Service Capacity for Substance Abuse Treatment for Families Involved with Child Welfare

Problem: There is a shortfall in system capacity, accessibility and seamless delivery. Therefore, it does not address the treatment needs of substance abusing child welfare clients and their families. Additionally, the treatment system needs to build more ongoing coordination of services among all systems; throughout the continuum of care. As this system is developed, nationally recognized best practices should be utilized in serving the needs of the target population.

Recommendation:

To establish a regionalized continuum of care that is replicable and utilizes nationally recognized best practices. Programs are to be developed or enhanced that are tailored to the specific needs of the child welfare client and family (including pregnant women). Throughout the continuum of care child safety outcomes need to be integrated into treatment planning, reassessment, discharge and follow-up.

Increase availability and accessibility of the entire continuum of substance abuse services that are specialized and outcome driven to meet the needs of this population. Consequently, enhance the opportunity for families to get well from their substance abuse disorders while improving the child welfare outcomes of safety, permanency and well-being.

Measure the impact of substance abuse treatment services on child welfare outcomes.

Discussion: The shortfall in capacity along the continuum of care of substance abuse treatment providers to service child welfare families is a significant barrier. In 1997, a Child Welfare League of America study of state child welfare agencies estimated that 67% of parents in the child welfare system required substance abuse treatment services, but child welfare agencies were able to provide treatment for less than one-third of these families. Furthermore, in most states, the wait for treatment services was up to 12 months.

In 2002, there were over 56,000 treatment admissions reported to the Division of Addiction Services (DAS) in the New Jersey Department of Health and Senior Services. In 1998, DAS estimated that on an annual basis approximately 700,000 people in New Jersey need treatment.

Using national data, it is estimated that 25% of those needing substance abuse treatment services would actually seek it out and attend treatment. Consequently, in New Jersey for every one of the 56,000 people accessing treatment, three additional people need treatment and would take the steps to access the services if they were available.

The current data shows 31% of all of DAS admissions to be female. Recognizing the complexities associated with the female addict, DAS spends \$9.5 million annually as a set-aside, specifically to enhance and maintain a network of substance abuse treatment programs with wrap around services (child care, transportation, etc.) specifically designed to meet the unique needs of women of childbearing age, pregnant women, and women with dependent children.

Additionally, DAS' county allocations distributed by the Local Advisory Committee on Alcoholism and Drug Abuse (LACADA) purchase alcohol and drug treatment services. The needs assessment for each county drives the purchase of care for women.

Appreciating that large numbers of individuals entered treatment for substance abuse in New Jersey, there remains a deficiency in the system to service the universe of individuals needing treatment. This scarcity in access to treatment services is even more pronounced for DYFS families for whom the prevalence of substance abuse is estimated to be in the range of 40 to 80%.

Of the 31% or approximately 17,000 women who entered treatment in 2002, the Department of Human Services estimates that less than one third were DYFS mothers. Statewide, an estimate of DYFS families requiring and ready to access treatment services ranges from a minimum of 4,838 people utilizing 1,613 treatment slots annually to 15,479 utilizing 5,160 treatment slots. In addition, the substance abuse treatment system capacity that is specialized to service women and children can service 2,199 families annually utilizing 733 treatment slots. The minimum DYFS need for substance abuse treatment slots annually is 1,613

treatment slots. Currently, 733 slots exist in specialized treatment capacity to serve women and children. The shortfall in system capacity is estimated to be 880 specialized treatment slots statewide at a minimum. This does not account for the additional service capacity required to meet the special needs of their children and adolescents.

To break the link between child abuse and substance abuse, families need help from supportive and integrated systems and resources. While child welfare workers are aware that most of their cases involve families with drug and alcohol problems, few systematic resources and programs are in place to effectively serve families needing substance abuse treatment. The result is that parents who need addiction treatment rarely obtain it and when they fail to show progress in parenting, they may lose their children permanently, due to addiction (Alcohol, and Other Drugs, & Child Welfare, 2001).

The inability to access treatment services for DYFS clients is directly related to the lack of treatment funds set aside for the Child Protection Substance Abuse Initiative (CPSAI) program in New Jersey. As mentioned earlier, there are no explicit resources set aside to fund treatment services for families. Following assessment, CPSAI consultants work with diagnosed families to place them in an appropriate level of care utilizing available resources for treatment within the Department of Health and Senior Services' licensed provider network.

In addition, to date few studies document the impact of substance abuse treatment services on child welfare outcomes. This research is critical to continue to identify the best strategies for ensuring children are safe and that parents in recovery improve their caretaking capabilities.

3. Evaluate Families Holistically – Intervene Early: Safety and Service Plans Must Be Built Upon the Strengths of the Family While Addressing Permanency (Reunification) Issues for Children

Problem: High protective service and resource needs exist for families with substance abuse issues. Children from substance abusing households are more likely than others to be placed into foster care, spend longer periods of time in an out-of-home setting, are less likely to return home within one year of placement, and are more likely to have a case goal of adoption.

Alcohol and drug use by a pregnant woman is devastatingly harmful to the unborn child. These infants are more likely to have serious medical complications at birth and continue experiencing behavioral, developmental and medical needs throughout their lifetime. Substance use affects all aspects of family life, interferes with positive family functioning and in most situations, perpetuates the cycle of substance abuse and child abuse/neglect.

Over time, most families affected by substance abuse interface with multiple state and community resources. These resources may lack orientation to the family's complex and multiple needs. Coupled with the serious impact associated with substance abuse on safety, permanency and well being, a timely and comprehensive response to effect an overall system change is needed as a first step toward ensuring that children are first and foremost protected from abuse and neglect.

Recommendation:

Promote early and appropriate intervention and prevention for high risk families in the areas of substance abuse and child welfare.

- **Develop Case Practice Standards for District Office staff of the Division of Youth and Family Services (DYFS) relative to substance abuse screening, assessment, and intervention. Share standards with substance abuse treatment providers, welfare agencies, court system and community agencies partnering with DYFS in serving families and children. Evaluate the impact of the new case practice standards.**
- **Following the full implementation of new DYFS Case Practice Standards, thorough DYFS training and successful expansion and enhancement of substance abuse treatment capacity and improved access to care for DYFS families, consider instituting mandatory substance abuse drug screening and testing for families referred to and under DYFS supervision and applicants to the foster and relative caregiver programs.**
- **Ensure an appropriate number of Certified Alcohol and Drug Counselors (CADC) and Home Visitor resources are in place in all DYFS District Offices and Adoption Resource Centers (ARCs). Evaluate the impact these resources have on substance abuse and child welfare outcomes.**

Recommendation:

Meet the medical, developmental and mental health needs of children impacted by substance abuse.

- **Hire an additional 48 nurse/pediatric nurse practitioners and ensure an appropriate nurse supervisor to consultant ratio. Ensure the availability of at least two nurses per district office or Adoption Resource Center to partner with DYFS in meeting the complex needs of children in the child welfare system. Nurses will assist in meeting these needs by: working with DYFS field staff in assessing the health and developmental needs of children throughout the life of a case (for children in their own home and out-of-home placement); ensuring that children receive services such as referrals for Fetal Alcohol Syndrome (FAS) screens, and neuro-developmental evaluations to address substance abuse issues as part of an overall fostering healthy children initiative; ensuring children are current in**

immunizations and documentation is shared with caretakers; and ensuring access to other community based resources and follow-up by providing much needed support to relative caretakers, birth families, foster parents and other identified caretakers.

- Evaluate the impact of these additional resources on child physical and mental health and well-being.

Recommendation:

Expand Regional Diagnostic and Treatment Centers' assessment and support services to include home visitor services that utilize a best practice parenting education model.

- Current treatment resources that are child and adolescent specific should be expanded to support children in their own homes or in out-of-home placements. Consideration should be given to enhancing funding for the Regional Diagnostic Treatment Centers to provide comprehensive assessments, psycho-social education and support programs and intervention/treatment approaches geared to children and adolescents in a family-centered model.
- Evaluate the impact of parenting education on child safety and physical and mental health and well-being.

Discussion: Child welfare workers may view abusive parents with alcohol or drug addictions as part of the problem instead of as clients whose strengths and needs require as much emphasis as their deficits. Some child welfare workers question the effectiveness of treatment. Confidentiality protocols actually mask alcohol and drug problems among child welfare populations. Most child welfare workers have not connected with substance abuse treatment professionals. Due to lack of information about policy issuances, confidentiality concerns are often cited as a reason to forgo collaboration based on lack of trust rather than confidentiality actually presenting legal barriers (Young and Gardner, 2002).

Children in substance-abusing families are at double jeopardy — they are both biologically and environmentally at risk. Moreover, the interplay between biological and environmental factors is extremely significant because biological problems can be exacerbated or mitigated by environmental influences.

For example, a home environment that is responsive and nurturing can help reduce the negative developmental effects of prenatal substance abuse exposure. On the other hand, an environment that does not provide adequate nurturing can increase the risk of negative developmental outcomes associated with prenatal substance exposure.

An array of medical conditions is frequently present in children who were prenatally substance-exposed that require careful observation. Often a parent's substance abuse can interfere with his/her ability to meet a child's basic needs. Parents need support from a health care team made up of the parent or

caregiver and child welfare and health care professionals to actively communicate and clarify the child's existing medical condition and follow-up needs, and required level of care giving.

Prenatally drug and alcohol exposed infants and young children are also at increased risk for developmental problems. Developmental screening in drug and alcohol-exposed children is critical because early intervention and early identification of developmental problems are key to optimizing the children's social, language, cognitive and motor development. Through home-, center-, and school based programs, children affected by parental alcohol and/or other drug abuse can be exposed to enriched environments and given opportunities that will foster their developmental potential (National Center on Child Abuse and Neglect, 1994).

Substance abuse and dependence are other long-term consequences of child maltreatment which often surface as young children exposed to parental substance abuse reach adolescence. A study of incarcerated adolescents found that sexual abuse had a direct effect on drug use while physical abuse had an indirect effect on drug use mediated by self-derogation (Dembo et. al, 1987). Another study examining the relationship between a history of physical and sexual abuse and drug and alcohol related consequences found that 81% of women and 69% of men currently receiving inpatient detoxification services reported past physical and sexual abuse, starting at a median age of 13 and 11 respectively (Liebschutz, et, al 2002).

The question of whether or not mandatory measures are effective in substance abuse treatment was weighed by the work group especially concerning pregnant women with or without other children. While noting that compulsion can be a therapeutic step in initiating treatment interventions and long-term recovery from substance abuse, there is consensus among experts that punitive approaches to perinatal substance abuse do not promote the best interests of women or their children (Sexton, 2003).

Organizations such as the American Medical Association, the American Academy of Pediatrics, the American Public Health Association, the American Nurses Association, the Society on Addiction Medicine, and the March of Dimes have opposed the prosecution of substance-using pregnant women in part fearing that such prosecutions would deter women from obtaining necessary health care and would thus cause harm to both maternal and fetal health (Sexton, 2003).

Other compulsory approaches that do not involve civil prosecution of the mother include civil interventions by child protective service agencies and/or family drug courts. Study findings lend some support to coercive approaches that mandate treatment and maintain family unity as the most effective approach. These

findings underscore the need for family centered programs that provide adequate space for infants and children as well as child care services (Sexton, 2003).

On the whole, legal scholars have argued that unless the state provides significant treatment programs for a pregnant woman, it should be unable to remove her children or terminate her parental rights (Sexton, 2003).

4. Systems Collaboration

Problem: Because many of the families in New Jersey involved with child welfare and in need of substance abuse services are also interacting with TANF, mental health, and family court, an approach of systems integration and collaboration is essential and holds the most potential for positive change.

To build more effective bridges between child welfare services and substance abuse treatment services it is important to recognize that it is not a “stand alone” issue, but rather is linked with delinquency, family violence, welfare reform, mental health and the need for a stronger community role in supporting families. While we lack comprehensive data as to how many clients are served concurrently in TANF, child protective services, and substance abuse treatment, numerous studies have documented that these multi-problem families are the highest risk clients in each of these systems (Young and Gardner, 1997).

Recommendation:

Establish a Statewide Advisory Committee on Substance Abuse and Child Welfare (SACSACW) to implement the blueprint of recommendations developed by the subcommittees contained herein. Specifically, the SACSACW would:

- **Advocate for and initiate the availability of appropriate on-demand substance abuse treatment for families and women of childbearing age and improved capacity along the continuum of care.**
- **Recommend practice guidelines impacting the delivery of services to children and families involved with DYFS and other child welfare systems to the Governor’s Cabinet for Children.**
- **Serve as a conduit in gathering sensitive community-based information from county-wide local Community Steering Committees and Coalitions on Substance Abuse and Child Welfare.**
- **Ensure that whatever changes are made on the state level are carried through to the local level.**
- **Maintain scheduled communication with the sub-committees.**
- **Provide a forum to support professional systems responsible for the delivery of health and human services to create a system of checks and balances in order to ensure accountability and standards of care are employed to treat the most vulnerable.**

Recommendation:

The Division of Youth & Family Services will establish county-wide Interagency Coalitions on Substance Abuse and Child Welfare to:

- Advocate for appropriate on-demand substance abuse treatment for families and women of child bearing age.
- Recommend and review practice guidelines impacting the delivery of services to children and families involved with DYFS and other systems providing services with the SCSACW.
- Collaborate with and serve as a conduit in gathering community-based information from the county-wide Steering Committees in order to incorporate the identified needs into program/policy changes.
- Maintain scheduled communication with the SCSACW and ensure that whatever changes are made on the local level are communicated to the state level.
- Seek to facilitate formal and informal community partnership agreements.
- Seek to foster formal and informal agreements regarding time-sensitive, efficient, case-management services.
- Establish affiliation agreements between DYFS and other agencies that provide wraparound services and case management services.
- Provide a forum to support professional systems responsible for the delivery of health and human services to create a system of checks and balances in order to ensure accountability and standards of care are employed to treat the most vulnerable.

Discussion: Collaborative working relationships are important for several reasons:

- They enable service providers to meet a broader range of family needs;
- They allow agencies to better coordinate their efforts and ensure that they never overwhelm families with requirements nor impose conflicting demands; and
- They enable a more efficient use of limited resources and prevent inefficient parallel program development (U.S. Department of Health and Human Services, 1999).

An important, yet often overlooked, factor hindering collaboration is how different systems may hold conflicting values around such profound issues of child abuse, substance abuse and poverty. Child Welfare and Substance Abuse systems typically have differing fundamental concepts of who is the client, the two systems have contrary responses to licit and illicit drugs, the workers have different educational backgrounds, and systems define success differently, and have distinct funding streams.

Perhaps the primary values conflict between the two systems is that for a child welfare worker the client is both the child and the family with the safety of the child as the primary short-term concern and the risk for the child the longer range priority. For substance abuse workers clients are generally adult substance abusers and people in recovery and their status as a parent is generally secondary (Young et. al., 1998).

Value differences such as these must be placed on the table for open discussion and common ground must be discovered in order to foster meaningful and effective collaborations across systems.

In addition, services such as mental health, health care, housing, transportation, welfare, and domestic violence must be integrated and coordinated to effectively serve families. If these separate systems cannot forge closer links, each will be forced to work within its own limited resources, when it is clear that the resources of more than one system are paramount to meeting the needs of families with multiple problems.

Alongside collaboration, as a key to sustaining the kind of innovative system reform warranted by the complex nature of the problems, leadership matters. Leadership is important to innovation in several ways. First, leadership can ensure that the roots of the innovation grow as deep as possible. The skills and attitudes of the staff chosen to implement the innovative reforms are the critical ingredients of reform. Second, leaders at their best articulate a vision and then guide a team in a clear set of actions that carries out the vision. Third, leaders must harness the resources needed for innovation (Young et. al, 1998). To successfully achieve collaboration, the leadership from all coordinating entities must work to actively advance innovative reforms.

Problem: In addition to the systems collaboration that must take place between Child Welfare Systems and Substance Abuse Treatment Systems, other systems intended to serve the complex needs of families experiencing both substance abuse and child abuse and neglect must also be brought into the fold of collaboration.

In particular, at least 75% of all child welfare cases that pass through the family court system are in some way affected by substance abuse. However, judges, Deputies Attorney General, DYFS staff, Law Guardians and Public Defenders have not been provided sufficient information on substance abuse and how to coordinate/collaborate with substance abuse systems, programs, and services such that they might make properly informed decisions on child safety, permanency and well-being to meet the ASFA time frames.

The lack of a “systems coordinator” to coordinate the progress of DYFS-TANF court (and non-court) cases makes it difficult to hold stakeholders accountable to follow through on their responsibilities in a timely manner.

By fostering collaboration across these systems the flow of information from the treatment providers to the court and DYFS would improve and all stakeholders accountable for their part in serving the client and the children involved can be held to a similar standard.

Recommendation:

A flexible model of family supervision entitled “Project Safety” should be designed and implemented. This model should provide a systems coordinated approach to family supervision for DYFS-TANF families affected by parental substance abuse. The program design should establish clear measures of parental/caretaker accountability combined with coordinated services provided through the DYFS and TANF systems to enhance families’ capacity to provide for children’s needs. A model with these aspects would make it possible to maintain children at home or remove them for short periods of time (one or two months) while the parent complies with intensive outpatient or inpatient treatment. The project would coordinate with the core state and local systems (e.g. courts, DYFS, TANF and service providers) that affect children’s safety, permanency and well-being through, law, regulation, policies, programs and services.

The project would use the DYFS Family Preservation Principles (FPS) and In-Home Visits along with TANF Parental Accountability Principles (PAP) to ensure that children in DYFS-TANF families are safely maintained in their home when parents/caretakers have substance use disorders (SUD).

The project would ensure the children’s’ safety, permanency and stability in their living situations through services, home visits and family monitoring. Parents/caretakers would have enhanced capacity to provide for children’s needs through a coordinated array of TANF-DYFS funded services (e.g. substance abuse treatment, mental health services, parenting-skills, welfare-to-work activities, DYFS caseworker in-home family preservation services, TANF caseworker in-home and school visits, child care, transportation, transitional housing, cash assistance, food stamps, Medicaid, kinship care services, child support, child assessment and treatment).

Recommendation:

The Family Court in Morris County received a federal grant for engaging in the process of planning for the establishment of a Family Drug Court. The Department of Human Services, Division of Youth and Family Services should coordinate with the Administrative Office of the Courts to review the progress of the Morris County Family Court in their process of planning

for a Family Drug Court for child welfare families and collaborate on the viability of establishing such a pilot court in Morris County in anticipation of the consideration of the implementation of Family Drug Courts statewide.

Recommendation:

Provide orientation and on-going training to increase the abilities, skills and knowledge of Family Court judges, staff and Child Placement Review Board Volunteers, Deputies Attorney General, Law Guardians, and Public Defenders on best practices for substance abuse treatment in order to manage families affected by substance abuse.

Currently, judges, Deputies Attorney General, Law Guardians and Public Defenders lack sufficient skills and knowledge of substance abuse and how to coordinate/collaborate with substance abuse systems, programs, and services such that they might make properly informed decisions on child safety, permanency and well-being to meet the ASFA time frames.

Utilize an evidenced based training curriculum for orientation of new court personnel and ongoing training modules that target specific areas of importance to court personnel. The delivery structure of training would need to be sufficiently flexible to accommodate the different schedules of staff.

Discussion: Although only a small percentage of substantiated child abuse and neglect cases get to court, those that do are heard exclusively in civil court proceedings. In general, criminal prosecution is not a common legal intervention in child maltreatment cases that involve either parental or parental substance abuse. The aim of the civil court is protection of the child while the parent is in treatment.

In considering the level of protection needed by children in substance abusing families and the treatment services required by their parents, the courts must typically weigh a number of factors including:

- The child's health, development and educational status
- The child's age
- Parental history of alcohol or other drug abuse and substance abuse treatment
- Parenting profile
- Safety of the home
- Family supports
- Treatment resources

Decisions regarding the family's functioning and progress must be based on the comprehensive assessment information contributed by a variety of disciplines

and agencies. States receiving Federal funds for foster care must make reasonable efforts to prevent unnecessary placement of children out of the home and return children to their homes as early as possible (NCCAN, 1994).

Often, due to system's coordination and collaboration issues, comprehensive information and/or services have not been compiled on behalf of families to enable judges to assess fully if the parental substance abuse is detrimental to the well-being of a child and may create a substantial risk of harm and if reasonable efforts to provide appropriate services have been underway.

The court system can be viewed as one potential intervention to help ensure safety for children and encourage substance-abusing family members to begin moving toward recovery. However, empowered with model programs that increase access to treatment services alongside aggressive monitoring and accountability while allowing children to remain in the home, the courts will have a wider array of tools at its fingertips to effectively motivate families.

D. Conclusion

Families with substance abuse and child welfare issues want a better life for themselves and their children. This report and the recommendations provide a blueprint to offer families an improved opportunity to achieve sobriety, family, and safety. The power of the recommendations derives from: its stark recognition of the scope and prevalence of substance abuse and the role it plays in child maltreatment; its emphasis on strengths based interventions and staff development; its approach to integration and collaboration; and its commitment to improved access to treatment resources.

The economic cost of substance abuse to the U.S. economy each year is estimated at over \$414 billion. This cost affects the whole of society, those with substance abuse issues and those without. The cost represents not only direct costs like treatment and property losses, but also productivity losses resulting from premature death, and the inability to perform usual activities (Schneider Institute for Health Policy, 2001). Coupled with the impact of child maltreatment on individual families and society as a whole, the expenditures are staggering and far outweigh the resources necessary to implement the changes proposed by the work group.

This report advocates for action. It lays a framework stipulating that in order to expand substance abuse treatment, design family centered interventions, and meet complex multi-service needs, collaboration must occur across social service delivery systems, state agencies, branches of government and professional disciplines. Involving community stakeholders and families in fashioning solutions is vital to their success.

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VI. Acronyms

AOD	Alcohol and Other Drugs
ARC	Adoption Resource Centers
ASAM	American Society of Addiction Medicine
ASFA	Adoption and Safe Families Act
CADC	Certified Alcohol and Drug Counselor
CCC	Clinical Care Coordinators
CFSR	Child and Family Services Review
CPRB	Child Placement Review Board
CPSAI	Child Protection Substance Abuse Initiative
CSW	Certified Social Worker
CWA	County Welfare Agencies
CWLA	Child Welfare League of America
DAG	Deputy Attorney General
DAS	Division of Addiction Services
DHS	Department of Human Services
DHSS	Department of Health and Senior Services
DMAHS	Division of Medical Assistance and Health Services (Medicaid)
DO	District Offices in the Division of Youth and Family Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
DYFS	Division of Youth and Family Services
FAS	Fetal Alcohol Syndrome
GA	General Assistance
HHS	U.S. Department of Health and Human Services
IOP	Intensive Outpatient
LACADA	Local Advisory Committee on Alcoholism and Drug Abuse's
MICA	Mentally Ill Chemical Abuser
MMT	Methadone Maintenance Therapy
NIDA	National Institute on Drug Abuse
PSSFP	Promoting Safe and Stable Families Program
PTSD	Post Traumatic Stress Disorder
RAPC	Residentially Assisted Partial Care slots
RDTC	Regional Diagnostic and Treatment Center
SAI	Substance Abuse Initiative
SAMHSA	Substance Abuse and Mental Health Services
SARD	Substance Abuse Research Demonstration
SACSACW	Statewide Advisory Committee on Substance Abuse and Child Welfare
SUD	Substance use disorder
TANF	Temporary Assistance for Needy Families
WFNJ	Work First New Jersey

VII. Appendices

APPENDIX A.

EXECUTIVE ORDER NO. 36

WHEREAS, the New Jersey Division of Youth and Family Services in the Department of Human Services will undergo federal review of its agency under the Children and Family Services Review (“CFSR”) conducted by the United States Department of Health and Human Services, Administration for Children and Families, beginning with a self assessment in 2003 and an onsite review in or about March 2004; and

WHEREAS, the CFSR monitors and evaluates the States child and family services, including protective services, family preservation and support, foster care, independent living and adoption services; and

WHEREAS, the New Jersey Division of Youth and Family Services is establishing a steering committee for the participation of external stakeholders as required by the United States Department of Health and Human Services, Administration for Children and Families, and has commenced the preparation for the CFSR; and

WHEREAS, a portion of the CFSR will monitor and evaluate systematic factors, such as service array accessibility to such circumstances as domestic violence and substance abuse; and

WHEREAS, there exists involvement of all branches of government and multiple levels within these branches of government in circumstances such as domestic violence and substance abuse; and

WHEREAS, September is Substance Abuse Awareness Month and October is Domestic Violence Awareness Month; and

WHEREAS, the Governor has expressed his strong support of the improvement of services for New Jersey’s children and families; and

WHEREAS, the Governor has expressed his commitment to partner with other branches of government to work collaboratively to improve the services New Jersey provides to its citizens; and

WHEREAS, the Legislature has expressed a desire to partner with the Department of Human Services to conduct its own review of the interplay between domestic violence and the welfare of children and families and the interplay between substance abuse and the welfare of children and families;

NOW, THEREFORE, I, JAMES E. McGREEVEY, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the statutes of this State, do hereby ORDER and DIRECT:

1. The Commissioner may jointly conduct hearings with the Legislature where joint invitations are sent to interested parties for participation in two hearings; one involving the interplay between domestic violence and the welfare of children and families, the other involving the interplay between substance abuse and the welfare of children and families.

2. The Commissioner, in cooperation with the Legislature, may establish two separate work groups, one for domestic violence and one for substance abuse, the membership of which shall be comprised of persons jointly recommended, representatives of various branches of government, various State departments, community providers, advocacy groups, and interested parties, provided that at least two persons from the existing steering committee formed by the Division of Youth and Family Services under the CFSR, shall be a member of each work group to facilitate shared ideas, to avoid duplication and to promote cooperative endeavors for the common goal.

3. Within one year, the work groups shall present a joint report to the Commissioner and the Legislature in open session, focusing on how the various branches and levels of government, the various State departments, the multitude of

community partners, advocacy groups and interested parties can be instrumental in the Division of Youth and Family Services better serving the interests of children and families through implementation of initiatives regarding issues of domestic violence and substance abuse, across systems in a collaborative fashion. The report shall include, but not be limited to, recommendations regarding modifications of existing policies/procedures and legislation/regulations, as well as interdepartmental and advocacy group partnerships, as may be applicable.

4. This Order shall take effect immediately.

Two,
States,

GIVEN, under my hand and seal, this
23rd day of October
in the Year of Our Lord, Two Thousand
and of the Independence of the United
the Two Hundred and Twenty-Seventh

/s/ James E. McGreevey
Governor

[seal]
Attest:

/s/ Paul A. Levinsohn
Chief Counsel to the Governor

APPENDIX B.

Implications of the Recommendations by Branch of Government

Executive Branch

- 1. Establish a Statewide Advisory Committee to the Governor's Cabinet for Children on Substance Abuse and Child Welfare (SACSACW) to implement the blueprint of recommendations developed by the subcommittees contained herein.**
- 2. DYFS will organize and co-facilitate Countywide Interagency Coalitions on Substance Abuse and Child Welfare to coordinate and integrate county-wide information from all groups that provide substance abuse prevention, treatment, and wraparound services to children and families.**
- 3. Establish a regionalized continuum of care that is replicable and utilizes nationally recognized best practices.**
 - Programs are to be developed or enhanced that are tailored to the specific needs of the child welfare client and family (including pregnant women).**
 - Throughout the continuum of care child safety outcomes need to be integrated into treatment planning, reassessment, discharge and follow-up.**
- 4. Establish and implement a Certified Alcohol and Drug Training Program for Family Case Workers and Supervisors to develop a well-trained corps of Certified Family Case Workers and Supervisors to enhance the child protection system and environment.**
 - The training programs must be skill-based, grounded in strong case practice methodologies. The Family Case Worker Training Program should include the relationship and effect of poverty on family dynamics, child development (including trauma and disabilities associated with prenatal exposures), alcohol and drug issues, mental health issues, criminal justice issues, and ethical decision-making. The program should include training in the use of environmental safety and risk assessment. The training may include didactic elements but should emphasize interactive learning techniques that have practical applications.**
 - The Supervisor Training Program must include administrative skill-building, including morale, recognizing and addressing**

worker burn-out and stress, collegial support and case conceptualization for problem-solving and decision-making.

- 5. Develop Case Practice Handling Standards for field staff of the Division of Youth and Family Services (DYFS). Share standards with substance abuse treatment providers, welfare agencies, court system and community agencies partnering with DYFS in serving families and children. Case practice handling standards should include protocols for mandatory substance abuse drug screening and testing for families referred to and under DYFS supervision and applicants to the foster and relative caregiver programs.**
- 6. Ensure an appropriate number of Certified Alcohol and Drug Counselors (CADC) and Home Visitor resources are in place in all DYFS District Offices (DO) and Adoption Resource Centers (ARCs).**
- 7. Hire an additional 48 nurse/pediatric nurse practitioners and ensure an appropriate nurse supervisor to consultant ratio. Ensure at least two nurses per DO/ARC office to partner with DYFS in meeting the complex needs of children in the child welfare system.**
- 8. Expand Regional Diagnostic and Treatment Center Assessment and Support Services to include home visitor services that utilize a best practice parenting education model.**
- 9. "Project Safety" -- A systems coordinated model of family supervision for DYFS-TANF families affected by parental substance abuse.**

Judicial Branch

- 1. The Department of Human Services, Division of Youth and Family Services would coordinate with the Administrative Office of the Courts to review the progress of the Morris County Family Court in their process of planning for a Family Drug Court for child welfare families and collaborate on the viability of establishing such a pilot court in Morris County in anticipation of the consideration of the implementation of Family Drug Courts statewide.**
- 2. Provide orientation and on-going training to increase the abilities, skills and knowledge of Family Court judges, staff and volunteers, Deputies Attorney General, DYFS staff, Law Guardians and Public Defenders about substance abuse and the best practices to manage families affected by substance abuse.**

Legislative Branch

- 1. Consider policy recommendations from the permanent Statewide Advisory Committee on Substance Abuse and Child Welfare (SACSACW) for legislative action.**
 - **SACSACW will conduct a policy review to interpret existing State and Federal mandates and confidentiality laws that drive each department/division that impacts on family reunification or permanency planning.**
 - **Identify Policies and Procedures currently guiding the substance abuse and child welfare communities that can be amended within the confines of the law, based on best practices, in order to enhance interagency case management, support treatment options for the entire family, that are complimentary to the needs of each family member.**
- 2. Pass budget appropriations to adequately fund the following:**
 - **A regionalized continuum of care for substance abuse treatment services for families involved with child welfare that is replicable and utilizes nationally recognized best practices.**
 - **A Certified Alcohol and Drug Training Program for DYFS Family Case Workers and Supervisors to develop a well-trained corps of Certified Family Case Workers and Supervisors to enhance the child protection system and environment.**
 - **DYFS staff and agency capacity enhancements including:**
 - 1) An appropriate number of CADC and Home Visitor resources in place in all DYFS District Offices and Adoption Resource Centers;**
 - 2) An additional 48 nurse/pediatric nurse practitioners and ensure an appropriate nurse supervisor to consultant ratio. Ensure at least two nurses per District Office and Adoption Resource Center to partner with DYFS in meeting the complex needs of children in the child welfare system; and**
 - 3) Regional Diagnostic and Treatment Center Assessment and Support Services to include home visitor services that utilize a best practice parenting education model.**
 - **Innovative program models including:**

- 1) “Project Safety” -- A systems coordinated model of family supervision for DYFS-TANF families affected by parental substance abuse.**
 - 2) The Department of Human Services, Division of Youth and Family Services’ and Administrative Office of the Courts’ review of the progress of the Morris County Family Court in their process of planning for a Family Drug Court for child welfare families.**
- Cross Systems Training including orientation and on-going training to increase the abilities, skills and knowledge of Family Court judges, staff and volunteers, Deputies Attorney General, DYFS staff, Law Guardians and Public Defenders about substance abuse and the best practices to manage families affected by substance abuse.**

APPENDIX C.

SUBCOMMITTEE RECOMMENDATIONS AND WORK PLANS

**Child & Family Services Review
Substance Abuse Work Group
Collaboration Subcommittee Task Sheet**

Problem Statement:

There are barriers that hinder communication across systems, adversely affecting integration of services, and thwart consensus on common goals.

These barriers include:

- ❖ Confidentiality
- ❖ State & Federal Requirements
- ❖ Conflicting time lines
- ❖ Separate funding streams
- ❖ Differing philosophical premises guiding agency policies and procedures
- ❖ Legal issues
- ❖ Lack of understanding regarding the Disease of Addiction
- ❖ Policies and procedures differ from agency to agency
- ❖ Stigma towards women who use alcohol and other drugs
- ❖ Lack of community partnerships that are integrated
- ❖ Different internal symbols and languages, misunderstood by outside agencies and clients
- ❖ Different measures of success from agency to agency
- ❖ Resources (time and money) not built into every system, (i.e. human resources are staff trained and do they have adequate staffing to complete assignments adequately?)
- ❖ Prevention efforts are not cross-referenced with varying emphasis
- ❖ Cultural competence-availability of programs/staff
- ❖ Compartmental approach to services/ limited professional expertise
- ❖ Third party insurance is diagnosis driven and not family treatment driven

**Child & Family Services Review
Substance Abuse Work Group
Collaboration Subcommittee Task Sheet**

Recommendation 1. Establish a Statewide Advisory Committee on Substance Abuse and Child Welfare.

Purpose	<p>The Statewide Advisory Committee on Substance Abuse and Child Welfare (SACSACW) will:</p> <ol style="list-style-type: none"> 1) Advocate for and initiate the availability of appropriate on-demand substance abuse treatment for families and women of childbearing age and improved capacity along the continuum of care. 2) Recommend practice guidelines impacting the delivery of services to children and families involved with DYFS and other child welfare systems to the Governor's Cabinet for Children. 3) Serve as a conduit in gathering sensitive community-based information from county-wide local Community Steering Committees and Coalitions on Substance Abuse and Child Welfare. 4) Ensure that whatever changes are made on the state level are carried through to the local level. 5) Maintain scheduled communication with the work group subcommittees. 6) Provide a forum to support professional systems responsible for the delivery of health and human services to create a system of checks and balances in order to ensure accountability and standards of care are employed to treat the most vulnerable.
Description	<p>This permanent Statewide Advisory Committee on Substance Abuse and Child Welfare (SACSACW) will be established to coordinate and integrate information from all groups that provide substance abuse prevention, treatment, and wraparound services to children and families based on the blueprint of recommendations developed by the subcommittees contained herein. The Statewide Advisory Committee will recommend research, evaluation, and policy review activities. Its Executive Committee will be responsible for prioritizing recommendations made by the subcommittees and making needed updates and changes in order to clear the way to operationalize and make policy changes.</p> <p>Membership on the SACSACW will include the following representatives;</p> <ul style="list-style-type: none"> ❖ At least 3 Child Welfare consumers who also received AOD Services including at least one aging-out adolescent,; ❖ Division of Youth & Family Services (including the director and staff who handle substance abuse/child welfare issues); ❖ Department of Community Affairs/Housing; ❖ Administrative Office of the Courts, including Family Court, Criminal Court, Drug Court and Probation; ❖ Division of Family Development;

	<ul style="list-style-type: none"> ❖ Division of Mental Health (Child and Adult Psychiatric/dual diagnosis); ❖ Division of Addiction Services (Child and Adult, Prevention, and Treatment Addiction/Dual Diagnosis); ❖ Maternal & Child Health (Prenatal Addiction Prevention Projects); ❖ HIV/AIDS; ❖ American Society of Addiction Medicine, including an expert in the Standards of Care for the treatment of pregnant substance abusing patients; ❖ New Jersey Protection and Advocacy; ❖ Association of School Superintendents; ❖ Attorney General (Office on Policy Development and Planning), ❖ Department of Corrections; ❖ Juvenile Justice Commission; ❖ Medicaid; ❖ Researcher with expertise in Substance Abuse Treatment and Child Welfare,; ❖ Three experts in substance abuse treatment programs for pregnant women and their children representing each region of New Jersey (i.e., North, Central, South); ❖ Representative from the Fatherhood Initiative; ❖ Representative from the New Jersey Senate Health, Human Services and Senior Citizens Committee; ❖ Representative from the New Jersey Assembly Family, Women and Children Committee; ❖ New Jersey Council on Domestic Violence; ❖ March of Dimes; ❖ Chairs of the local Community Steering Committees; and ❖ Chairs of the Interagency Coalitions on Substance Abuse and Child Welfare.
Action Steps	<p>The Co-Chairs of the SACSACW will establish guidelines for the ad hoc committee and develop a schedule for meetings with:</p> <ol style="list-style-type: none"> 1) The Chairs of the local Community Steering Committees. 2) The Chairs of the Interagency Coalitions on Substance Abuse and Child Welfare. 3) Chairs of the Treatment, Court, DYFS, and Training Committees established by Commissioner of Human Services. 4) The SACSACW will provide technical assistance and information to the Governor's Cabinet for Children. 5) Relevant Information gathered at the Children's Cabinet meeting would be communicated to the membership during the regularly scheduled Statewide ACSA meetings. 6) The SACSACW will communicate recommendations to the Children's Cabinet, Legislature, and the Governor of New Jersey.

Lead/Others Responsible	<ul style="list-style-type: none"> ❖ The Assistant Commissioner of Addiction Services and the Director of the Division of Youth & Family Services will Co-Chair the Statewide Advisory Committee on Substance Abuse and Child Welfare. ❖ The Executive Committee will be developed from the SACSACW Committee membership. Membership will also include the chairpersons from the Treatment, Courts, DYFS, and Training Subcommittees of the Substance Abuse Work Group; chairpersons from four Community Steering Committees representing the North, Central, Western and Southern New Jersey areas; and chairpersons from the Northern, Central, Western, and Southern New Jersey Interagency Coalitions on Substance Abuse and Child Welfare. ❖ The Statewide Advisory Committee on Substance Abuse and Child Welfare will be established by Executive Order for a period of three years; and will be renewed yearly for so long as it is determined that the SACSACW should exist.
Time Frame	<p><u>SHORT TERM:</u></p> <ul style="list-style-type: none"> ❖ The Statewide Advisory Committee on Substance Abuse & Child Welfare will seek to become organized by January 2004. ❖ The Co-Chairs will establish contact with the chairs of the local Community Steering Committees, and County-Wide Interagency Coalitions on Substance Abuse and Child Welfare. Meeting will take place with the current subcommittee leaders of Training, DYFS, and Court to secure the blueprints of recommendations. <p><u>INTERMEDIATE:</u></p> <ul style="list-style-type: none"> ❖ The Executive Committee will meet monthly. ❖ Attend the Governor's Children's Cabinet, as scheduled. ❖ The Statewide Advisory Group will meet regularly as set by the Executive Committee.
Comments	<p>This Statewide Advisory Committee on Substance Abuse will seek to clarify, interpret, and recommend practice guidelines on the local and state level affecting families affected by the Disease of Addiction.</p>

Examples of Research & Evaluation Projects	<p><u>EXAMPLES OF SHORT-TERM PROJECTS:</u></p> <ul style="list-style-type: none"> ❖ Review and interpret existing State and Federal mandates and confidentiality laws that drive each department/division that impacts on family reunification or permanency planning. ❖ Identify Policies and Procedures currently guiding the substance abuse and child welfare communities that can be amended within the confines of the law, based on best practices, in order to enhance interagency case management, support treatment options for the entire family, that are complimentary to the needs of the family. <p><u>EXAMPLES OF INTERMEDIATE PROJECTS:</u></p> <ul style="list-style-type: none"> ❖ Develop formal Statewide Memorandums (MOA) of Agreement. ❖ Ensure the MOA are replicated on the local level. An example of a local MOA include, county/local affiliation agreements between the DYFS, County Boards of Social Services , and School Districts that agree to develop a system of notification in order to share information and pool resources <p><u>EXAMPLES OF LONG-TERM PROJECTS:</u></p> <ul style="list-style-type: none"> ❖ A system of Quality Assurance developed to ensure system collaboration, agency satisfaction, and client satisfaction. ❖ Develop a Grievance system for agencies.
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**Child & Family Services Review
Substance Abuse Work Group
Collaboration Subcommittee Task Sheet**

Recommendation 2. The Division of Youth and Family Services will establish county-wide Interagency Coalitions on Substance Abuse and Child Welfare.

Purpose	<p>The Division of Youth & Family Services will establish county-wide Interagency Coalitions on Substance Abuse which will:</p> <ol style="list-style-type: none"> 1. Advocate for appropriate on-demand substance abuse treatment for families and women of child bearing age. 2. Recommend and review practice guidelines impacting the delivery of services to children and families involved with DYFS and other systems providing services with the SACSACW. 3. Collaborate with and serve as a conduit in gathering community-based information from the county-wide Steering Committees in order to incorporate the identified needs into program/policy changes. 4. Maintain scheduled communication with the SACSACW and ensure that whatever changes are made on the local level are communicated to the state level. 5. Seek to facilitate formal and informal community partnership agreements. 6. Seek to foster formal and informal agreements regarding time-sensitive, efficient, case-management services. 7. Establish affiliation agreements between DYFS and other agencies that provide wraparound services and case management services. 8. Provide a forum to support professional systems responsible for the delivery of health and human services to create a system of checks and balances in order to ensure accountability and standards of care are employed to treat the most vulnerable.
Description	<p>DYFS will organize and co-facilitate county-wide Interagency Coalitions on Substance Abuse and Child Welfare established to coordinate and integrate county-wide information from all groups that provide substance abuse prevention, treatment, and wraparound services to children and families. The county-wide Coalitions on Substance Abuse and Child Welfare will mirror the membership represented on the Statewide Advisory Committee on Substance Abuse and Child Welfare.</p> <p>Membership on the county-wide Interagency Coalition on Substance Abuse and Child Welfare will include:</p>

	<ul style="list-style-type: none"> ❖ At least three child welfare consumers who also received AOD Services including at least one aging-out adolescent; ❖ Division of Youth and Family Services; ❖ Department of Community Affairs/Housing; ❖ Administrative Office of the Courts, including Family Court; ❖ Criminal Court, Drug Court, Probation, and Division of Family Development; ❖ Division of Mental Health, including Dual Diagnosis; ❖ Division of Addiction Services; ❖ Maternal & Child Health Consortium; ❖ HIV/AIDS; ❖ American Society of Addiction Medicine, including an expert in the Standards of Care for the treatment of pregnant substance abusing patients; ❖ New Jersey Protection and Advocacy; ❖ Association of School Superintendents; ❖ Head Start and/or other Early Preschool Representative; ❖ Attorney General's Office on Policy; ❖ Department of Corrections; ❖ Juvenile Justice Commission; ❖ Medicaid; ❖ Researcher with expertise in substance abuse treatment and child welfare; ❖ Experts in substance abuse treatment programs for pregnant women and their children representing each county; ❖ Representative from the Fatherhood Initiative; ❖ Representative from the Senate Health, Human Services and Senior Citizens Committee; ❖ Representative from Assembly Family, Women and Children's Services Committee; and ❖ Representative from the domestic violence advocacy community.
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Examples of Research & Evaluation Projects	<p><u>EXAMPLES OF SHORT-TERM PROJECTS:</u></p> <ul style="list-style-type: none"> ❖ Review policies and procedures currently guiding substance abuse treatment and child welfare that can be amended within the confines of the law, in order to become complimentary of the needs of the family. <p><u>EXAMPLES OF INTERMEDIATE PROJECTS:</u></p> <ul style="list-style-type: none"> ❖ Develop formal local Memorandums of Agreement (MOA). Examples of a local MOA include county/local affiliation agreements between DYFS, County Boards of Social Services, and school districts that agree to develop a system of notification in order to share information and pool resources. <p><u>EXAMPLES OF LONG-TERM PROJECTS:</u></p> <ul style="list-style-type: none"> ❖ Quality Assurance system developed to ensure system collaboration, agency satisfaction, and client satisfaction. ❖ Development of a grievance procedure for systems and agencies.
Lead/Others Responsible	<p>The local DYFS district office will co-lead the interagency coalition with the Divisions of Addiction Services, and the Division of Mental Health Services.</p>
Timeframe	<p><u>SHORT TERM:</u></p> <ul style="list-style-type: none"> ❖ The countywide Interagency Coalitions on Substance Abuse will seek to become organized by January 2004. ❖ The Co-leaders of the Coalition will establish contact with the chairs of the local Community Steering Committees. ❖ Establish contact with the Statewide Advisory Committee on Substance Abuse. <p><u>INTERMEDIATE:</u></p> <ul style="list-style-type: none"> ❖ The Interagency Coalitions on Substance Abuse will meet monthly. ❖ The Community Steering Committees chairs will be members of the Executive Committee.

**Child & Family Services Review
Substance Abuse Work Group
Treatment Subcommittee Task Sheet**

Problem Statement:

There is a shortfall in system capacity, accessibility and seamless delivery. Therefore, it does not address the treatment needs of substance abusing child welfare clients and their families are not addressed. Additionally, the treatment system needs to build more ongoing coordination of services among all systems; throughout the continuum of care. As this system is developed nationally recognized best practices must be utilized in serving the needs of the target population.

**Child & Family Services Review
Substance Abuse Work Group
Treatment Subcommittee Task Sheet**

Recommendation 1. To establish a regionalized continuum of care that is replicable and utilizes nationally recognized best practices. Programs are to be developed or enhanced that are tailored to the specific needs of the child welfare client and family (including pregnant women). Throughout the continuum of care child safety outcomes need to be integrated into treatment planning, reassessment, discharge and follow-up.

Purpose	The purpose of this recommendation is to increase availability and accessibility of the entire continuum of substance abuse services that are specialized and outcome driven to meet the needs of this population. Consequently, enhance the opportunity for families to get well from their substance abuse disorders while improving the child welfare outcomes of safety, permanency and well-being.
Description	<p>Establish a continuum of care that includes: prevention, outreach, recruitment, education, screening, referral, treatment and ongoing cross-system case management especially for high-risk women and children involved with multiple systems. The various treatment levels of care must include evaluation, detoxification, residential, outpatient, intensive outpatient, partial care, and outpatient methadone maintenance for each individual population (i.e., adolescents, pregnant women, women with children, and parenting fathers). The following must be identified throughout the continuum: rewards and sanctions; process and outcome evaluation starting at point of entry; services for children; and co-occurring disorders. *All services need to be gender specific, culturally relevant, outcomes based, individualized and delivered on demand. **All programs must incorporate and provide directly, or through linkage agencies, wrap around services, children's services including primary prevention and treatment, therapeutic child care services, children of substance abuse (COSA) services, follow-up services etc. ***All levels of care must offer a drug free model and a methadone maintenance model.</p> <ul style="list-style-type: none"> a. Develop and provide all necessary resources (i.e., facilities, capital, adequate per diem rates) to support a system that delivers services from outreach to follow-up on a regional basis. b. Outreach, recruitment and education: there should be an outreach team in each county to provide outreach recruitment and assessment to this high-risk population. c. Creates statewide screening, assessment and referral on demand for this population. d. At a minimum, create regional hospital based detoxification service. e. Expand sub-acute detoxification services regionally. f. Create statewide ambulatory care detoxification services. g. Expand residential treatment beds on a regional basis.

	<p>h. Expand services for extended care, halfway houses, transitional living programs and housing on a regional basis.</p> <p>i. Create and expand the entire continuum of outpatient services from partial care to traditional outpatient services.</p>
Action Steps	<p>1. Conduct joint strategic planning between the Departments of Health and Senior Services and Human Services (see collaboration sub-committee) (already initiated).</p> <p>A. Complete a comprehensive licensed treatment service capacity and demand assessment to identify gaps in treatment and needed priorities as a preamble to the joint strategic planning process. (Short Term)</p> <p>B. Across the continuum of care identify organizations that are most ready to meet the special needs of the target population in the format described above. (Short Term)* In this case, "ready" means those already serving the population, those most willing to incorporate the identified principles, those who have underutilized capacity and those willing and able to increase capacity.</p> <p>C. Design, develop and implement the technical assistance needed to make this enhanced service system a reality.</p> <p>D. Provide adequate funding in capital and service delivery. (Intermediate)</p> <p>E. Develop and implement a process and outcome evaluation plan to measure the impact of substance abuse treatment services on child welfare outcomes. (Short, Intermediate and Long Term)</p> <p>F. While the planning process and implementation is occurring move to immediately expand some capacity in residential and intensive outpatient. (Short Term)</p> <p>G. DHS and DAS identify and create an information technology solution that identifies common clients and that meets federal confidentiality laws and regulations. (Long Term)</p> <p>H. Change, create or enhance policies that support the treatment and recovery process (i.e., supportive rather than punitive approaches), allowance of time required for recovery.</p>
Lead	<p>Department of Human Services (DHS) and Division of Addiction Services (DAS) Join Strategic Plan Committee, The Children's Cabinet, Providers and Consumers</p>
Timeframe	<p><u>SHORT TERM</u>: Aug 15, 2003 – January 15, 2004 ; <u>INTERMEDIATE</u>: January 15, 2004- July 15, 2005 <u>LONG TERM</u>: July 15, 2005- July 15, 2007</p>

**Child & Family Services Review
Substance Abuse Work Group
Training Subcommittee Task Sheet**

Problem Statement:

DYFS Family Case Workers and Supervisors lack comprehensive, skill-building training programs that are based on established best case practices. The current training system does not insure consistency across regions and districts nor is there an evaluation system in place to assess the quality of training (process) as well as the capability of Family Case Workers and Supervisors to impact child safety and welfare positively and effectively (outcome).

In addition, other professionals interacting with children and families daily require education to raise awareness about the impact of substance abuse on child welfare. Such sensitivity will better enable systems and individual workers to provide the most appropriate and comprehensive services to families.

**Child & Family Services Review
Substance Abuse Work Group
Training Subcommittee Task Sheet**

Recommendation 1. Establish and implement a Certified Substance Abuse Training Program for Family Case Workers and Supervisors under the purview of the Addictions Professionals Certification Board of New Jersey.

Purpose	To develop a well-trained corps of Certified Family Case Workers and Supervisors to enhance the child protection system and environment.
Description	<p>The training programs must be skill-based, grounded in strong case practice methodologies. The <u>Family Case Worker Training Program</u> should include the relationship and effect of poverty on family dynamics, child development (including trauma and disabilities associated with prenatal exposures), alcohol and drug issues, mental health issues, criminal justice issues, and ethical decision-making. The program should include training in the use of environmental safety and risk assessment. The training may include didactic elements but should emphasize interactive learning techniques that have practical applications.</p> <p>The <u>Supervisor Training Program</u> must include administrative skill-building, including morale, recognizing and addressing worker burn-out and stress, collegial support and case conceptualization for problem-solving and decision-making.</p>
Certification Contents	<p><u>Alcohol and Drug Family Case Manager Certification</u> This two year program requires a total of the following 60 contact hours of training. Coursework will focus on building skills in the following courses.</p> <ol style="list-style-type: none"> 1. Substance Use Disorder (SUD) Bio-psychosocial Assessment – 18 hours 2. Assessment of Domestic Violence, Sexual, and Physical Abuse, Trauma, Neglect, and other areas– 18 hours. 3. Dynamics of the Individual and Family effected by SUD – 6 hours 4. Recovery in the Individual and Family effected by SUD – 6 hours 5. Effects of SUD across the Lifespan, (including Perinatal and FAS.) – 6 hours 6. Ethics and Legal Issues, (including Drug Courts), of the SUD DYFS client. – 6 hours <p><u>Alcohol and Drug Family Case Manager Supervisor Certification</u> This 30-hour program for DYFS Supervisors is focused on building the skills to increase expertise in the “hands</p>

	<p>on” supervision of DYFS Case Managers. Supervisors will have completed the Alcohol and Drug Family Case Manager Certification.</p> <ol style="list-style-type: none"> 1. Principles of Supervision – 6 hours 2. Advanced Supervision (to include Defense Mechanisms, Transference/Counter-Transference, Attitudes, etc.)- 6 hours 3. DSM and ASAM – 6 hours 4. Drug Courts and Legal Issues- 6 hours 5. Advanced Domestic Violence Issues – 6 hours <ul style="list-style-type: none"> • All courses will be in a workshop format in 3 or 6-hour blocks of time. • A statewide panel of experts from DYFS and the Addiction Field will develop the knowledge and skill learning objectives, as well as experience and ethical standards, for both certifications • Recertification for each certification will require 30 hours of continuing education in Human Services and the Addiction field every two years.
Lead/Others Responsible	The Addiction Professionals Certification Board will administer these certifications. An Advisory Group, comprised of experts from DYFS and the Addiction Field, will be established within the Certification Board to make recommendations and to review applications.
Timeframe	<p><u>SHORT TERM:</u> (3 months) 1) Panel established to develop curricula in consultation with the Addictions Professionals Certification Board of New Jersey. The evaluation system should be designed in conjunction with the development of the curricula. (The Training Committee will serve in this capacity with additional support from members of the AOD Work Group.) and 2) Open communications with the unions to foster collaboration and support in the implementation of the Training Program.</p> <p><u>INTERMEDIATE:</u> (6 months) Conduct competitive vendor solicitation process to select best contractor(s) to implement initial training and re-certification programs. The contractor must insure consistency in training across the state.</p> <p><u>LONG TERM:</u> (1 year) All Family Case Workers and Supervisors mandated to participate in the Training Programs.</p>
Comments	DYFS Foster parents and other stakeholders should be allowed to participate in the trainings, when appropriate.

**Child & Family Services Review
Alcohol and Drugs Work Group
Training Subcommittee Task Sheet**

Recommendation 2. Educate and raise awareness of the impact of substance abuse on child welfare among all professionals that touch the lives of children every day.

Purpose	To develop a fully educated and aware professional response to the coinciding issues of substance abuse and child maltreatment especially among, but not limited to: the Juvenile and Adult Criminal Justice systems, substance abuse and mental health clinicians, and Work First New Jersey staff.
Description	The education efforts should utilize the curricula developed in consultation with the Addictions Professionals Certification Board of New Jersey as a touch stone, and further customize it to meet the specific needs and circumstances of the various professional agencies.
Lead/Others Responsible	The Training Committee of the Substance Abuse Work Group will serve as the panel to establish the framework of the education programs, in consultation with DYFS.
Timeframe	<p><u>SHORT TERM:</u> (3 months) 1) Panel established to develop curricula in consultation with the Addictions Professionals Certification Board of New Jersey. The evaluation system should be designed in conjunction with the development of the curricula. (The Training Committee will serve in this capacity with additional support from members of the AOD Work Group.)</p> <p><u>INTERMEDIATE:</u> (6 months) Conduct competitive vendor solicitation process to select best contractor(s) to implement initial education programs. The contractor must insure consistency in education across the state.</p> <p><u>LONG TERM:</u> Core group of agencies registered to participate in the Education Programs.</p>

**Child & Family Services Review
Substance Abuse Work Group
Court Systems Subcommittee Task Sheet**

Problem Statement:

People who struggle with substance abuse often fail to seek help because they do not know how to secure services, and fear that if they engage in treatment they run the risk of losing their children and other supportive family services. At least 75% of all child welfare cases that pass through the family court system are in some way affected by substance abuse. However, judges, Deputy Attorney Generals, DYFS staff, Law Guardians and Public Defenders lack a sufficient knowledge of substance abuse and how to coordinate/collaborate with substance abuse systems, programs, and services such that they might make properly informed decisions on child safety, permanency and wellbeing to meet the ASFA time frames.

The lack of a “systems coordinator” to coordinate the progress of DYFS-TANF court (and non-court) cases makes it difficult to hold stakeholders accountable to follow through on their responsibilities in a timely manner. It is not yet clear as to whether this “systems coordinator” should be a state employee (or through which Department/agency) or whether this position should be contracted out to a private agency). It is hoped that this type of facilitation will help speed the flow of information from the treatment providers to the court and DYFS, as well as hold all stakeholders accountable for their part in serving the client and the children involved. Without this new structure/role, it would be difficult to consider more flexible requirements for the removal of children from parents where substance abuse is identified as a concern.

A flexible model of family supervision would need clear measures of parental/caretaker accountability combined with coordinated services provided through the DYFS and TANF systems to enhance the families’ capacity to provide for the children’s needs. A model with these aspects would make it possible to maintain children at home or remove them for short periods of time (one or two months) while the parent complies with intensive outpatient or inpatient treatment.

**Child & Family Services Review
Substance Abuse Work Group
Court Systems Subcommittee Task Sheet**

Recommendation 1: “Project Safety” A systems coordinated model of family supervision for DYFS-TANF families affected by parental substance abuse.

Purpose	<p>The project would coordinate with the core state and local systems (e.g. Courts, DYFS, TANF and Service Providers) that affect children’s safety, permanency and wellbeing through, law, regulation, policies, programs and services.</p> <p>The project would use the DYFS Family Preservation Principles (FPS) and In-Home Visits along with TANF Parental Accountability Principles (PAP) to ensure that children in DYFS-TANF families are safely maintained in their home when parents/caretakers have substance use disorders (SUD).</p> <p>The project would ensure the children’s’ safety, permanency and stability in their living situations through services, home visits and family monitoring. Parents/caretakers would have enhanced capacity to provide for children’s needs through a coordinated array of TANF-DYFS funded services (e.g. substance abuse treatment, mental health services, parenting-skills, welfare-to-work activities, DYFS caseworker in-home family preservation services, TANF Caseworker in-home and school visits, child care, transportation, transitional housing, cash assistance, food stamps, Medicaid, kinship care services, child support, child assessment and treatment).</p> <p>The project would ensure children’s educational, developmental, physical and emotional needs are assessed to determine if treatment or other services are appropriate. Children would receive adequate services to meet those needs.</p>
Description	<p>The project would use regular home visits to assess the families’ environment and child risk. It would use engagement and accountability interventions to promote parental responsibility. For example, parents’ attendance at services and urine drug screens (UDS) would be tracked monitored and reported to the DYFS and TANF case workers. Regular attendance (75% or higher) and negative UDS would be reinforced with low cost vouchers (\$20.00). It would require parental answerability on the use of their children’s welfare benefits (e.g. cash assistance and food stamps) and use “protective payee” and other benefit supervision strategies when parents have positive UDS. Parents would sign performance contracts with clear and achievable goals and responsibilities. The contracts would include incentives for meeting performance outcomes and sanctions</p>

	<p>for non-compliance.</p> <p>In situations when the child(ren) are temporarily removed from the parent/caretaker home, case management services would follow the child(ren) to the home(s) of physical custody to ensure a safe transition and enhance the child(ren)'s coping abilities.</p> <p>The project would create <u>systems coordination roles and structures on the state and local levels</u>. State and county <u>Systems Coordinators</u> would be linked to facilitate communication and resolve systems problems in a short timeframe. Systems Coordinators would develop policies and operational mechanisms that</p> <ul style="list-style-type: none"> ✓ Integrate and prioritize different systems' requirements, ✓ Link together parallel TANF and DYFS funded services already existing in the community. ✓ Hold agencies accountable for access to services and service delivery and parents accountable for progress. <p>The project would link families to existing services because linkages to existing services are cost-effective and reduce multiple episodes of disconnected care. It would expand service capacity when gaps or over utilization are identified. It would track and monitor parental access and engagement in services across multiple systems and communicate progress to each agency managing the family's case.</p>
Action Steps	<p>The court systems sub committee, state and local planners would work with external consultants from the National Center on Addiction and Substance Abuse (CASA) to implement the following:</p> <ul style="list-style-type: none"> ✓ Conduct a community analysis of systems and resources available to the target population in several counties. ✓ Map-out the systems, agencies, service providers and services available and identify 4 to 6 counties with the most robust community infrastructure (e.g. information management systems, multi-agency case conferencing capacity, agencies commitment to communicate and coordinate on services and shared clients, an array of quality services and responsive delivery structures) to implement a multi-systems coordinated project. ✓ Select the counties where the project would be phased in. ✓ Restructure existing TANF-DYFS contracted services to reduce duplication, fragmentation and under or over utilization. ✓ Create systems coordination policies, structures and operational mechanisms on the state and local levels that would integrate systems and services, promote parental accountability, and keep children safe. <p>Collaborate with state planners to develop and implement other aspects of the model such as Systems Coordinator, Cross-Systems Case Management, and Outcomes Evaluation.</p>

Lead/Others Responsible	<p>Lead: DYFS Designee and DFD Designee</p> <p>Others: Representatives from the Administrative Office of the Courts, the Department of Law and Public Safety, the State Legislature, the provider community, and other experts in the field.</p>
Timeframe	<p><u>SHORT TERM:</u> 0 to 4 months</p> <ul style="list-style-type: none"> √ Conduct a community analysis of systems and resources available to the target population in several counties. Map-out the systems, agencies, service providers and services available and identify 4 to 6 counties with the most robust community infrastructure (e.g. information management systems, multi-agency case conferencing capacity, agencies commitment to communicate and coordinate on services and shared clients, an array of quality services and responsive delivery structures) to implement a multi-systems coordinated project. Select the counties where the project would be phased in. <p><u>INTERMEDIATE:</u> 4 to 6 months</p> <ul style="list-style-type: none"> √ Create systems coordination policies, structures and operational mechanisms on the state and local levels that would integrate systems and services, promote parental accountability, and keep children safe. √ Collaborate with state planners to develop and implement other aspects of the model such as Systems Coordinator, Cross-Systems Case Management, and Outcomes Evaluation. √ Interagency training <p><u>LONG TERM:</u> 6 months and ongoing</p> <ul style="list-style-type: none"> √ Phased –in implementation of 4 to 6 counties. √ Restructure existing TANF-DYFS contracted services to reduce duplication, fragmentation and under or over utilization.

**Child & Family Services Review
Substance Abuse Work Group
Court Systems Subcommittee Task Sheet**

Problem Statement:

At least 75% of all child welfare cases that pass through the family court system are in some way affected by substance abuse. However, judges, Deputy Attorney Generals, DYFS staff, Law Guardians and Public Defenders lack a sufficient knowledge of substance abuse and how to coordinate/collaborate with substance abuse systems, programs, and services such that they might make properly informed decisions on child safety, permanency and wellbeing to meet the ASFA time frames.

The implementation of an evidenced based “Family Drug Court Model” would assist judges, Deputy Attorney Generals, Child Guardian Services and Parent’s Legal Services in making informed recommendations to substance abusing families and to hold families/parents/caretakers accountable to follow through in a timely manner.

**Child & Family Services Review
Substance Abuse Work Group
Court Systems Subcommittee Task Sheet**

Recommendation 2: The Department of Human Services, Division of Youth and Family Services should coordinate and collaborate with the Administrative Office of the Courts to discuss the viability of establishing a pilot Family Drug Court for child welfare families in Morris County.

Purpose	Morris County Family Court received a federal grant to plan a Family Drug Court Program. In consultation with the Administrative Office of the Courts, Morris County would have to consider whether it would move ahead with applying to the federal government for an implementation grant.
Description	Coordinate with the Family Practice Division of the Judiciary, the Department of Addiction Services, The Division of Youth and Family Services, the New Jersey State Legislature, all other appropriate stakeholders and federal government funding in the development of a Family Drug Court process.
Action Steps	DYFS designees from the State Central Office and Northern Regional District Offices would collaborate with the Morris County Family Court and the Administrative Office of the Courts on the implementation of a pilot Family Drug Court program.
Lead/	Lead: Judiciary and DYFS Others: Administrative Office of the Courts. Judges, court staff, attorneys, DYFS, County and Municipal Welfare, Service and Treatment Providers.
Timeframe	<u>SHORT TERM</u> : 0 to 3 months ✓ Communication between Judiciary and DYFS on the current status of the Family Drug Court Planning Grant Application. ✓ Identify Multiple Systems stakeholders who would need to participate on an implementation and/or oversight work group. ✓ Identify what resources would be needed to implement the plan <u>INTERMEDIATE</u> : 4 to 6 months ✓ Develop an interim plan to improve coordination between DYFS and Family Court <u>LONG TERM</u> : 6 to 12 months Monitor status of the grant application.

**Child & Family Services Review
Substance Abuse Work Group
Court Systems Subcommittee Task Sheet**

Problem Statement:

Judges, Deputy Attorney Generals, DYFS staff, Law Guardians and Public Defenders lack a sufficient knowledge of substance abuse and how to coordinate/collaborate with substance abuse systems, programs, and services such that they might make properly informed decisions on child safety, permanency and wellbeing to meet the ASFA time frames.

**Child & Family Services Review
Substance Abuse Work Group
Court Systems Subcommittee Task Sheet**

Recommendation 3: Provide orientation and on-going training to increase the abilities, skills and knowledge of Family Court judges, staff and volunteers, Deputy Attorney Generals, DYFS staff, Law Guardians, Public Defenders and Child Placement Review Board volunteers about substance abuse and the best practices in order to manage families affected by substance abuse.

Purpose	Currently, judges, Deputy Attorney Generals, DYFS staff, Law Guardians and Public Defenders lack sufficient abilities, skills and knowledge of substance abuse and how to coordinate/collaborate with substance abuse systems, programs, and services such that they might make properly informed decisions on child safety, permanency and wellbeing to meet the ASFA time frames.
Description	An evidenced based training curriculum for orientation of new court personnel and ongoing training modules that target specific areas of importance to court personnel. The delivery structure of training would need to be sufficiently flexible to accommodate the different schedules of staff.
Action Steps	<ul style="list-style-type: none"> √ Conduct a substance abuse training needs assessment to determine abilities, skills and knowledge that judges, Deputy Attorney Generals, DYFS staff, Law Guardians and Public Defenders lack on substance abuse and how to coordinate/collaborate with substance abuse systems, programs, and services such that they might make properly informed decisions on child safety, permanency and wellbeing to meet the ASFA time frames. √ Contract with the Rutgers Center for Alcohol Studies (RCAS) to develop and possibly conduct some of the training. √ Evaluate the outcomes of the training.
Lead/	Lead: Judiciary Others: DYFS, RCAS, other stakeholders
Timeframe	<u>SHORT TERM:</u> 0 to 3 months <ul style="list-style-type: none"> √ Conduct a training needs assessment to determine abilities, skills and knowledge √ Identify costs and funding for the training. <u>INTERMEDIATE:</u> 4 to 6 months <ul style="list-style-type: none"> √ Secure funding. √ Develop and implementation plan. <u>LONG TERM:</u> 6 to 12 months Implement training.

**Child & Family Services Review
Substance Abuse Work Group
DYFS Subcommittee Task Sheet**

Problem Statement: *Promote early and appropriate intervention and prevention for high risk families to ensure child protection and permanency.*

Over the last two decades, child welfare agencies across the country have seen a dramatic rise in the prevalence of substance abuse and its direct impact on incidents of child abuse and neglect. Nationally, studies by the Child Welfare League of America have found that substance abuse is a factor in at least 75% of all placements of children in out-of-home care. The US Department of Health and Human Services estimates that there are as many as 8.3 million children living with substance abusing parents.

In New Jersey, the number of protective service cases involving substance abuse disorders is estimated to be between 75% and 80%. High protective service and resource needs exist for families with substance abuse issues. Children from substance abusing households are more likely than others to be placed into foster care, spend longer periods of time in an out-of-home setting, are less likely to return home within one year of placement, and are more likely to have a case goal of adoption.

Alcohol and drug use by a pregnant woman is devastatingly harmful to the unborn child. These infants are more likely to have serious medical complications at birth and continue experiencing behavioral, developmental and medical needs throughout their lifetime. Substance use affects all aspects of family life, interferes with positive family functioning and in most situations, perpetuates the cycle of substance abuse and child abuse/neglect.

Over time, most families affected by substance abuse interface with multiple state and community resources. These resources may lack orientation to the family's complex and multiple needs. Coupled with the serious impact associated with substance abuse on safety, permanency and well being, a timely and comprehensive response to effect an overall system change is needed. The Work Group convened by the Commissioner of the Department of Human Services and the recommendations put forth by the sub-committees of this group are a necessary first step in addressing the challenging goal of ensuring that children are first and foremost protected from abuse and neglect.

**Child & Family Services Review
Domestic Violence Work Group
DYFS Subcommittee Task Sheet**

Recommendation 1:

Purpose	Promote early and appropriate intervention and prevention for high risk families in the areas of substance abuse and child welfare.
Description	Develop Case Practice Standards for field staff of the Division of Youth and Family Services (DYFS). Share standards with substance abuse treatment providers, welfare agencies, court system and community agencies partnering with DYFS in serving families and children.
Action Steps	<ul style="list-style-type: none"> • Convene a work group lead by DYFS and include at a minimum, experts in the field of substance abuse, child welfare and the courts • Within, one year, explore existing models and develop a comprehensive set of case practice guidelines that provide consistency and address the specific and individualized case needs of families and children • Develop a work plan to train staff, implement and maintain these standards in all DYFS field offices • Implement standards into DYFS policy manual • Coordinate implementation efforts to ensure communication and distribution of standards to all stakeholders through joint working forums and comprehensive training • Evaluate the impact of the new case practice standards.
Lead/	Division of Youth and Family Services Include: Division of Addiction Services, Court representation
Timeframe	<u>SHORT TERM:</u> By 12/01/03- Identify Work Group representatives. <u>INTERMEDIATE:</u> By 2/01/03- Convene first meeting and develop work plan-Conduct monthly meetings to formulate guidelines. Invite individual experts as needed. <u>LONG TERM:</u> Within one year (by 12/31/04) present final draft of case practice standards.
Comments	Consider hiring a consultant to assist in this process

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Recommendation 2:

Purpose	Promote early and appropriate intervention and prevention for high risk families in the areas of substance abuse and child welfare.
Description	Ensure an appropriate number of CADC and Home Visitor resources are in place in all DYFS District Offices (DO) and Adoption Resource Centers (ARC).
Action Steps	<ul style="list-style-type: none"> • Determine existing resources and analyze need for additional CADC/Home Visitor resources per DO/ARC in each region. • Consider redistribution of existing resources as needed. • Continue Camden initiative to streamline SARD/SAI resources and work toward statewide implementation. • Initiate dialogue with current Child Protection Substance Abuse Initiative (CPSAI) providers. • Determine amount of fiscal resources necessary. • Make recommendation to DHS. • Evaluate the impact these resources have on substance abuse and child welfare outcomes.
Lead/Others Responsible	Division of Youth and Family Services Division of Addiction Services
Timeframe	<p><u>SHORT TERM:</u> By December 2003, meet with representatives from DO/ARC offices and conduct needs assessment; and by February 2004, meet with current Child Protection Substance Abuse Initiative providers to determine potential to expand services.</p> <p><u>INTERMEDIATE:</u> By February 1, 2004, make recommendation to DHS with identified projected cost.</p>

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Recommendation 3:

Purpose	Promote early and appropriate intervention and prevention for high risk families in the areas of substance abuse and child welfare.
Description	Following the full implementation of new DYFS Case Practice Standards, thorough DYFS training and successful expansion and enhancement of substance abuse treatment capacity and improved access to care for DYFS families, consider instituting mandatory substance abuse drug screening and testing for families referred to and under DYFS supervision as well as of applicants to the foster and relative caregiver programs.
Action Steps	<ul style="list-style-type: none"> • Evaluate the implementation of Case Practice Standards and training of DYFS staff. • Evaluate expanded and enhanced substance abuse treatment capacity and improved access to care for DYFS families. • Assess legal statute-policy implications. • Determine appropriate screening and testing technology and protocols. • Research similar programs existing in other states. • Determine cost factors. • Ensure drug screening is one piece of the investigation/assessment process through the development of utilization guidelines. • Develop system to measure outcomes and monitor effectiveness. • Consider pilot implementation in one county or region to begin with a statewide roll out plan.
Lead/Others Responsible	Department of Human Services Division of Youth and Family Services
Timeframe	<p><u>INTERMEDIATE</u>: Evaluate effectiveness of DYFS case practice standards and training. Demonstrate sufficient capacity and access to substance abuse treatment services for DYFS families. Research feasibility (legal/policy), projected cost, and programs in other states.</p> <p><u>LONG TERM</u>: Make recommendation to DHS with identified projected cost. Consider pilot in region/county and purchase kits, develop utilization guidelines and a system to measure outcomes.</p>

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Recommendation 4:

Purpose	Promote early and appropriate intervention and prevention for high risk families in the areas of substance abuse and child welfare. Meet the medical, developmental and mental health needs of children impacted by substance abuse
Description	<p>Hire an additional 48 nurse/pediatric nurse practitioners and ensure an appropriate nurse supervisor to consultant ratio. Ensure at least two nurses per DO/ARC office to partner with DYFS in meeting the complex needs of children in the child welfare system. Nurses will assist in meeting these needs by:</p> <ul style="list-style-type: none"> • Working with DYFS field staff in assessing the health and developmental needs of children throughout the life of a case (for children <i>in their own home</i> and out-of-home placement). • Ensure that children receive services such as referrals for Fetal Alcohol Syndrome (FAS) screens, neuro-developmental evaluations, etc. to address substance abuse issues as part of an overall fostering healthy children initiative. • Ensuring children are current in immunizations and documentation is shared with caretakers. • Ensure access to other community based resources and follow-up providing much needed support to relative caretakers, birth families, foster parents, and other identified caretakers.
Action Steps	<ul style="list-style-type: none"> • Obtain DHS approval to expand nursing resources. • Work with UMDNJ-FXB and Professional Nurse Consultants to expand pediatric nurse resources. • Consider hiring a least 2 nurses per region who are ASAM accredited or have background in the field of substance abuse treatment to serve as regional consultants. • Ensure there are at least two nurses per District Office/ARC. • Work with Nurse Consultant Supervisors to expand and update role to include an emphasis on identifying and working with families and children with substance use issues. • Provide all necessary training. • Evaluate the impact of these additional resources on child physical and mental health and well-being.

Lead/	Division of Youth and Family Services UMDNJ-FXB Center (covers nursing resources in Northern, Metropolitan and Central Regions) and Professional Nurse Consultants (covers Southern Region).
Timeframe	<u>SHORT TERM:</u> <ul style="list-style-type: none"> • Obtain DHS approval to further expand nursing resources. • Work with contract nursing agencies to expand nursing role. <u>INTERMEDIATE:</u> <ul style="list-style-type: none"> • Proceed with hiring of nursing staff. • Participate in orientation of new nursing staff to ensure an understanding of substance abuse related issues and identified expectations.
Comments	Additional nursing services are urgently needed statewide. Additional nurses will complement the overall Fostering Healthy Children Initiative and assist in the implementation of the health initiatives currently under development.

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Recommendation 5:

Purpose	Promote early and appropriate intervention and prevention for high risk families in the areas of substance abuse and child welfare. Expand Regional Diagnostic and Treatment Centers' (RDTC) Assessment and Support Services to include home visitor services that utilize a best practice parenting education model.
Description	<p>Current treatment resources that are child and adolescent specific should be expanded to support children in their own homes or in out-of-home placements. Consideration should be given to enhancing funding for the RDTCs to provide comprehensive assessments, psycho-social education and support programs and intervention/treatment approaches geared to children and adolescents in a family-centered model. Consideration to expanding/modifying the Division of Addiction Services' (DAS) Strengthening Families Program should also be considered.</p> <p>Increased and enhanced in-home visitor support service curriculum with an accompanying comprehensive parenting skills curriculum should be developed and utilized by RDTC providers and home visitor staff and include:</p> <ul style="list-style-type: none"> • Demonstrations, lectures and discussions; • Peer support; • Role playing, games and videos; • Interaction between parent and child; • Skill practice sessions; • Homework and review; and • Incentives for families.
Action Steps	<ul style="list-style-type: none"> • Work with DAS, RDTCs and other identified substance abuse experts to develop and submit proposal for a treatment model of services to support children who are impacted by substance abuse • Develop best practice parenting education model for in-home visitor services • Submit proposals to DHS • Discuss implementation possibilities with DHS • Evaluate the impact of parenting education on child safety and physical and mental health and well-being

Lead/Others Responsible	Division of Youth and Family Services Division of Addiction Services Regional Diagnostic and Treatment Centers for Abuse/Neglect
Timeframe	<u>SHORT TERM</u> : None identified. <u>INTERMEDIATE</u> : Initiate further discussion with lead agencies to explore feasibility.

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Recommendation 6:

Purpose	Ensure a comprehensive system of data collection to identify substance abuse issues and trends
Description	Design a system of data collection that captures essential substance abuse-related information
Action Steps	<ul style="list-style-type: none"> • Identify areas where data collection is needed • Share with DYFS Data Analysis Unit • Determine extent of information potential in consultation with SACWIS provider consultant agency
Lead/Others Responsible	Division of Youth and Family Services SACWIS Consultant
Timeframe	<p><u>SHORT TERM</u>: None identified.</p> <p><u>INTERMEDIATE</u>: Within 6 months, provide listing of areas where data collection is needed to DYFS Office of Information Technology.</p>